DELINEATION OF CLINICAL PRIVILEGES - ORAL & MAXILLOFACIAL SURGERY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Oral and Maxillofacial surgery is the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of disease, injuries, deformities, defects and esthetic aspects of the oral and maxillofacial regions.

NOTE: This document is to be used in conjunction with DA Form 5440-13, Delineation of Clinical Privileges - General Surgery.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Requested	Approved		Requested	Approved	
		ANESTHESIA			**RECONSTRUCTION**
		a. Nitrous oxide - minimal sedation			a. Maxillary, mandibular
		b. IV sedation - moderate sedation/analgesia			b. Facial
		c. IV sedation - deep sedation/analgesia			
		d. General anesthesia (ASA 1 AND 2)			**TEMPOROMANDIBULAR JOINT**
					a. Open joint, arthrotomy
		DENTOALVEOLAR SURGERY			b. Closed joint, arthroscopy
		a. Exodontia			c. Closed joint, arthrocentesis
		b. Alveoloplasty			d. Total joint reconstruction
		c. Exostosis removal			
		d. Vestibuloplasty, soft tissue management			**TRAUMA MANAGEMENT**
					a. Repair of facial, head, neck, oral lacerations
		IMPLANTS			b. Closed reduction of facial fractures
		a. Intraoral - endosteal			c. Open reduction of mandibular fractures
		b. Extraoral - endosteal			d. Open reduction of maxillary fractures (Le Fort I, II, III)
		c. Cosmetic - chin, zygomas, infraorbital, frontal			e. Open reduction of nasal fractures
					f. Open reduction of malar fractures
		PATHOLOGY			g. Open reduction of orbital fractures
		a. Oral, facial, neck, skin biopsies - to include minor salivary and parotid glands			h. Open reduction of frontal sinus fractures
		b. Removal of odontogenic and non-odontogenic bony or soft tissue tumors			i. Open reduction of zygomatic arch fractures
		c. Partial resection of the maxilla or mandible			j. Open reduction naso-orbital-ethmoidal complex fractures
		d. Maxillary sinusotomy			k. Tracheostomy, cricothyroidotomy
		e. Salivary gland surgery: submandibular and sublingual glands			
		f. Salivary gland surgery: parotid gland			**ORTHOGNATHIC JAW SURGERY**
		g. Treatment of oro-nasal and oro-antral communications			a. Maxillary osteotomy: Le Fort I
		h. Management of osteo-radio-necrosis			b. Maxillary osteotomy: Le Fort II and modified (subcranial) Le Fort II
		i. Vermilionectomy, wedge resection of lip			c. Maxillary osteotomy: Le Fort III

CLINICAL PRIVILEGES *(Continued)*

Requested	Approved	ORTHOGNATHIC JAW SURGERY *(Continued)*
		d. Mandibular osteotomy (intra-oral and extra-oral)
		e. Malar osteotomy
		ORAL - CERVICO - FACIAL INFECTIONS
		a. Incision and drainage (intra-oral and extra-oral)
		RECONSTRUCTIVE AND BONE GRAFT SURGERY
		a. Iliac bone harvest
		b. Rib harvest
		c. Calvarial bone harvest
		d. Tibial bone harvest
		e. Conchal and septal cartilage
		f. Abdominal fat
		g. Full and split thickness skin grafts
		h. Nerve harvest
		RECONSTRUCTIVE SURGERY
		a. Cleft lip and palate - primary closure
		b. Cleft lip and palate - secondary revision
		c. Alveolar cleft grafting
		d. Primary nerve graft repairs
		e. Secondary nerve graft repairs
		f. Regional grafts

Requested	Approved	RECONSTRUCTIVE SURGERY *(Continued)*
		g. Facial reconstruction and bone grafting procedures
		h. Hyoid suspension
		i. Pharyngoplasty
		FACIAL COSMETIC PROCEDURES
		a. Alloplastic augmentation
		b. Blepharoplasty
		c. Brow lift
		d. Cervicofacial liposuction, lipectomy
		e. Facial resurfacing procedures
		f. Septorhinoplasty
		g. Rhytidectomy
		h. Facial, neck, oral scar revision
		i. Otoplasty
		j. Medical treatment of facial rhytids (e.g., Botox injections)
		MISCELLANEOUS
		a. History and physical examination
		b. Hospital admission
		c. Reconstructive surgery with major flaps
		(1) Pedicle flaps
		(2) Microvascular flaps

LASER PRIVILEGES

Requests for laser privileges may require attendance at a formal laser training program(s), supporting documentation of training, experience, etc., acknowledgement of receipt of the MTF laser policy and procedural guidance, and review and approval by appropriate MTF personnel with oversight responsibilityfor laser therapy. The necessary documentation in support of this request is attached.

Requested	Approved	
		a. Laser Excision/Ablation of intraoral lesions.
		b. Laser Excision/Ablation of maxillofacial cutaneous lesions and facial rhytids.

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*