NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

OTOLARYNGOLOGY-HEAD & NECK
FACIAL PLASTIC SURGERY

Otolaryngology/ Head and Neck Surgical Procedures:

PRIVILEGE CRITERIA

1. Attestation (**Attachment 1 - in attestation format provided**)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of procedures in otolaryngology which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (**Attachments 2A and, depending upon privileges requested, Attachments 2B and 2C**)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in otolaryngology granted by the American Board of Otolaryngology or the American Osteopathic Board of Ophthalmology and Otorhinolaryngology or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in otolaryngology, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field) AND** active participation in examination process leading to certification in otolaryngology.

Use of Laser (Attachment 2B):

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, **OR**

(2) Documentation from the program director of an accredited resident training program attesting to the training in specific laser therapy during residency training.

Procedure Requiring Additional Training (Attachment 2C)

Licensee Name: _____ License Number: _____

I have attached, as Attachment 2C documentary evidence of the required additional training for the following procedure, if privileges are requested for this procedure:

Liposuction of the head and neck

additional training:

either

inclusion of, and successful completion of liposuction training in the course of instruction in the accredited otolaryngology-head & neck and facial plastic surgical specialty training program;

Or

completion of a liposuction training course that is sponsored by an Accreditation Council for Continuing Medical Education (ACCME) or AOA accredited provider of Category I CME, including Category I providers accredited by their state medical societies through ACCME's state recognition program, and which provides at least three (3) hours of training in a bioskills cadaver laboratory and which also **meets the criteria for** a minimum of eight (8) hours of Category 1 **credit towards the Physician's Recognition Award of the American Medical Association or has been** approved by the American Osteopathic Association for a minimum of eight (8) credit hours of **Category 1** continuing medical education ("CME");

plus

documentation (**additional reference Attachment 3A**) from a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s).

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privileges requested, Attachment 3A - in format provided):

References - Names, addresses and specialty, residency or observation only

I am providing, as Attachment 3, the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s). and whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

A. Reference for Requested Procedure(s) requiring additional training

I am providing, as Attachment 3A, the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s) **AND**

whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (**Attachment 4A, for each privilege requested - in format provided**)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type(s) of procedures for which I requested privileges, will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

<u>Requested Privileges</u>

_____ Surgery of outer ear - see also laser
_____ Tube placement into middle ear (myringotomy or tympanocentesis)
_____ Other (ear) *Please specify and provide supporting documentation on a separate page:* ____
_____ Electrocautery of anterior epistaxis
_____ Tonsillectomy/Adenoidectomy
_____ Surgery of external nose - see also laser

_____ Other (nose) *Please specify and provide supporting documentation on a separate page:* ____
_____ Endoscopic Procedures of Nasopharynx/larynx - see also laser
_____ Facial Plastic Surgery Procedures - see also laser. Please specify and provide supporting documentation on a separate page: ____

_____ Liposuction of the head and neck **- requires additional training**
_____ Other - Please specify and provide supporting documentation on a separate page: ____

Use of Laser: Requires additional training in specific laser use.

_____ Surgery of the outer ear: Ruby
_____ Surgery of the external nose: Ruby or CO2
_____ Endoscopic procedures of nasopharynx/larynx: CO2
_____ Facial plastic surgery procedures: Ruby (for pigmentation problems) and Candela

Please specify procedure(s) and laser (for each) and provide supporting documentation on a separate page: _____
_____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

_____
Signature and printed name of Applicant Date

Below this line for Administration Use Only

Application Tracking Record:
Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____