

**900 N MICHIGAN SURGICAL CENTER**

**PRIVILEGE REQUEST FORM  
OTOLARYNGOLOGY HEAD & NECK**

I am applying for the following privileges of which I am also currently credentialed at \_\_\_\_\_,  
an Illinois hospital.

<b>REQUESTED</b>	<b>GRANTED</b>	<b>PROCEDURE</b>
_____	_____	I & D abcess or hematoma face/neck
_____	_____	Excision, benign/malignant lesions of ear, face, neck, scalp
_____	_____	Local skin flaps face, neck, scalp
_____	_____	Pedicled skin flaps (all stages)
_____	_____	Skin grafts
_____	_____	Scar revision, head & neck
_____	_____	Facial dermabrasion
_____	_____	Chemical peel
_____	_____	Blepharoplasty
_____	_____	Rhytidectomy
_____	_____	Liposuction face/neck
_____	_____	Excision bone tumor, face/oral cavity
_____	_____	Excision mandibular/maxillary cyst
_____	_____	Application/removal interdental fixation
_____	_____	Facial bone augmentation
_____	_____	Reduction nasal fracture
_____	_____	Reduction zygoma/malar complex fracture
_____	_____	Nasal polypectomy
_____	_____	Excision nasal turbinate
_____	_____	Cryosurgery/cauterization nasal turbinates
_____	_____	Excision internasal lesion
_____	_____	Removal foreign body, nose
_____	_____	Rhinoplasty
_____	_____	Septoplasty
_____	_____	Repair septal perforation
_____	_____	Septodermoplasty

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<b>REQUESTED</b>	<b>GRANTED</b>	<b>PROCEDURE</b>
_____	_____	Repair oromaxillary fistula
_____	_____	Maxillary sinusotomy
_____	_____	Sphenoid sinusotomy
_____	_____	Internasal ethmoidectomy
_____	_____	Nasal/sinus endoscopy
_____	_____	Antrectomy, caldwell-luc
_____	_____	Laryngoscopy, microlaryngoscopy
_____	_____	Laser laryngeal surgery
_____	_____	Nasopharyngoscopy
_____	_____	Bronchoscopy
_____	_____	Esophagoscopy
_____	_____	Tracheoesophageal speech fistula
_____	_____	Closure tracheostomy fistula
_____	_____	Excision cervical lymph node
_____	_____	Biopsy/excision neck mass
_____	_____	Biopsy temporal artery
_____	_____	Excision lip lesion
_____	_____	Ankyloglossia repair
_____	_____	Excision intraoral lesion
_____	_____	Laser surgery oral cavity & oropharynx
_____	_____	Partial glossectomy
_____	_____	Biopsy/excision palate lesion
_____	_____	Sialolithotomy
_____	_____	Sialodochoplasty
_____	_____	Excision ranula
_____	_____	Excision submandibular gland
_____	_____	Excision sublingual gland
_____	_____	Parotidectomy
_____	_____	Biopsy/excision lesion pharynx
_____	_____	Excision brachial cleft cyst

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<b>REQUESTED</b>	<b>GRANTED</b>	<b>PROCEDURE</b>
_____	_____	Tonsillectomy
_____	_____	Adenoidectomy
_____	_____	Biopsy/excision external ear
_____	_____	Biopsy/excision ear canal
_____	_____	Removal foreign body ear canal
_____	_____	Debridement mastoid cavity
_____	_____	Otoplasty
_____	_____	Meatoplasty for acquired canal stenosis
_____	_____	Myringotomy/tube insertion
_____	_____	Middle ear exploration
_____	_____	Myringoplasty
_____	_____	Tympanoplasty
_____	_____	Mastoidectomy
_____	_____	Stapedectomy
_____	_____	<b>Other (Please Specify):</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Practitioner's Signature Print Name Date

\_\_\_\_\_  
Medical Director Approval, 900 N. Michigan Surgical Center Date

\_\_\_\_\_  
Governing Body Approval Date