



Name: \_\_\_\_\_

Date: \_\_\_\_\_

Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<p><b>Moderate (Conscious) Sedation</b> - Criteria for Approval:</p> <p>1. Proof of Current BCLS certification (please attach);</p> <p>2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment).</p> <p><i>(Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral &amp; Maxillofacial Surgery are not required to fulfill criteria 2.)</i></p>		
<p><b>Outpatient/Ambulatory Services:</b></p> <p>Practitioners granted core privileges in ambulatory care will provide services to patients in various outpatient clinic settings. The practitioner will routinely interact with patients as the primary care or ambulatory care provider. Services include:</p> <ul style="list-style-type: none"> <li>• General patient examination and care involving observation, assessment, planning, implementation and evaluation.</li> <li>• Ordering, Interpreting, and evaluating diagnostic tests to identify and assess patients' clinical problems and health care needs.</li> <li>• Performs Preventative health care counseling and instructs patients and/or families on treatment plans.</li> </ul> <p><b>Ambulatory Service locations are as follows:</b></p>		
<p><b>AeroDigestive Center:</b> Privileges include ambulatory core privileges as listed above in addition to: proctoscopies, rigid sigmoidoscopies, biopsies, excisions, incisions, drainages, G tube removals and changes, wound and skin debridements, wound care</p>		
<p><b>Plastics Clinic (NGE19L):</b> Privileges include ambulatory core privileges as listed above</p>		
<p>Other Procedures Not Listed</p>		

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Division Head's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department Head's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Confirming Signature  
(required if any privilege requested is not approved)

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR INITIAL PRIVILEGES FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

For which type of laser are you applying for privileges?

Carbon Dioxide _____ Argon _____ Nd-YAG _____ Other _____
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Approximately how many cases have you done with the laser?

Carbon Dioxide _____ Argon _____ Nd-YAG _____ Other _____
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For what types of surgery do you use the laser? \_\_\_\_\_

\_\_\_\_\_

**Formal courses taken in laser surgery:** Specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Training with lasers during residency and/or during practice:** Where it occurred, who supervised you, number of cases done with supervision, dates.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax it to 410-328-6433.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
APPLICATION FOR RECERTIFICATION FOR CLINICAL USE OF LASERS**

NAME: \_\_\_\_\_

DEPT/DIVISION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE: \_\_\_\_\_

**Current privileges are for the following lasers:**

<b>Carbon Dioxide</b> _____ <b>Argon</b> _____ <b>Nd-YAG</b> _____ <b>Other</b> _____
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*Please list the type of laser and procedures for which you are requesting continued privileges. (Use additional pages if needed for the following information.)*

TYPE OF LASER	PROCEDURES

*List the laser cases which you have done in the past two years:*

TYPE OF LASER	PROCEDURE	NUMBER DONE	NUMBER AND TYPE OF COMPLICATIONS, IF ANY

Since your original certification, have you had any further formal courses in laser surgery? If so, specify title of course, which types of lasers were used, institution where you took the course, date taken, number of hours of hands-on supervised use of the laser, CME credits earned. Enclose copy of CME certificate for the course.

\_\_\_\_\_

\_\_\_\_\_

After completing this form, please return it to Medical Staff Services, 110 South Paca Street, 8<sup>th</sup> Floor, Baltimore, MD 21201, or fax to 410-328-6433.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department/Division Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Credentials Committee Member

\_\_\_\_\_  
Date