**Work Sheet for Consideration of New Privilege**

**Name of procedure/privilege\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Education required to request privilege (check all that apply)**

MD - Medical Doctor

DO - Osteopathic Physician)

DDS - Oral and Maxillofacial Surgeon

DMD - Dentist

DPM - Podiatrist

APN – Advance Practice Nurse (specify specialty)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PA – Physician Assistant (specify specialty) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DC – Chiropractic

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Training Required:**

**Experience required**

**Additional Requirements:**

CME  Board Certification

Manufacturer’s Training Course/Certificate  Peer Recommendations

**Is monitoring or proctoring required?**

No  Yes.

*If yes, specify the following:*

In order to complete proctorship/monitoring requirements, the applicant must perform

\_\_\_\_\_\_\_\_\_ (number) procedures within \_\_\_\_\_\_\_\_\_\_\_\_\_(time frame).

What type of review or follow up will be conducted?