**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?