



CLINICAL CAPABILITIES

Otolaryngology

Please list any limitations or comments you may have on a separate sheet

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname
				Date of Birth
CERTIFICATIONS	<input type="checkbox"/> BLS expires: _____	<input type="checkbox"/> ACLS expires: _____	<input type="checkbox"/> ATLS expires: _____	<input type="checkbox"/> PALS expires: _____
			<input type="checkbox"/> NRP expires: _____	
POPULATIONS WORKED WITH	<input type="checkbox"/> Adult	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Trauma
AREAS OF INTEREST	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Trauma	
SCOPE OF PRACTICE	<p>Please check the box indicating which clinical capabilities you are able to perform, and where indicated, list the approximate number performed within the last 24 months.</p> <p>General otolaryngology – evaluation and management of disorders involving the ears, nose, throat, and skeletal facial structures</p> <p><input type="checkbox"/> Surgical – including tonsillectomy, adenoidectomy, PE tubes</p> <p><input type="checkbox"/> Non-surgical – including allergy desensitization, hearing evaluation, etc.</p> <p><input type="checkbox"/> Allergy testing</p>			
<p>Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.</p> <p>The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked, or where indicated, a number is not provided.</p>	Surgeries/Procedures:		Surgeries/Procedures:	
	<input type="checkbox"/> Endoscopic procedures #		<input type="checkbox"/> Thyroidectomy #	
	<input type="checkbox"/> Septal		<input type="checkbox"/> Extended parotidectomy #	
	<input type="checkbox"/> Sinus		<input type="checkbox"/> Radical neck surgery #	
	<input type="checkbox"/> Bronchoscopy - flexible		<input type="checkbox"/> Facial reconstruction * #	
	<input type="checkbox"/> Laryngoscopy		<input type="checkbox"/> Facial surgery #	
	<input type="checkbox"/> Tracheotomy		<input type="checkbox"/> Facial implants	
			<input type="checkbox"/> Blepharoplasty	
			<input type="checkbox"/> Rhinoplasty	
	<input type="checkbox"/> Laser certification (specify type)			

*DEFINITION: Facial reconstruction – facial fractures, cleft lip/palate repair, skin grafts/flaps

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____