ORAL AND MAXILLOFACIAL SURGERY

Surgeon name: ______________________________ CPSID: __________

Facility applying to: ______________________________

Please indicate only the procedures you wish to perform at the above-mentioned facility.

Face

- [ ] Biopsy
- [ ] Chin augmentation
- [ ] Cleft lip – bilateral complete
- [ ] Debridement – joint
- [ ] Drainage/aspiration
- [ ] Excision – scar
- [ ] Excision – tumour, cyst, soft tissue mass
- [ ] Facelift
- [ ] Irrigation and debridement
- [ ] Malar augmentation
- [ ] Mandibular osteotomy – internal fixation – bilateral
- [ ] Maxillary fracture zygomatic – arch – open reduction and wiring
- [ ] Maxillary fracture zygomatic – reduction
- [ ] Nasal fracture – wire plate fixation – open reduction
- [ ] Orbital floor open reduction
- [ ] Osteotomies, mandibular maxillofacial – bilateral
- [ ] Repair lacerations
- [ ] Scar revision

Dental

- [ ] Alveolectomy
- [ ] Caries
- [ ] Dental implants
- [ ] Extractions
- [ ] Minor oral surgery – root resections/dissections
- [ ] Pediatric dental – caries, extractions, excision lesions, restorations
- [ ] Restorations

Other

- [ ] TMJ arthroscopy

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Surgeon signature: ______________________________ Date: ______________________________