COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES ACCREDITATION PROGRAM

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Appropriate Procedures List
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: _____

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