



**Department of Surgery  
OPHTHALMOLOGY**  
Delineation of Privileges

\_\_\_\_\_  
Please Print Name

**QUALIFICATIONS:** Licensed physician (DO or MD) as defined in the Surgery Department Rules and Regulations with appropriate specialty training.

**Of the following, indicate particular privileges requested:** Privileges granted herein permit the surgeon to treat patients without limitations, for all inpatient and outpatient areas, intensive care units, and Emergency Department.

REQ = Requested APP = Approved

REQ	APP	Privilege Requested:
		Admit patients with ophthalmology problems; provide consultation for ophthalmological related problems; order diagnostic tests and procedures related to ophthalmological problems; and treat patients with ophthalmological problems.

**SPECIAL PROCEDURES:** Ophthalmologists with appropriate specialty training/experience are eligible to apply for the following special procedures, provided that specific criteria are met (when applicable).

REQ	APP	Privilege Requested:	REQ	APP	Privilege Requested:
		Lids (Ptosis, Entropion, Ectropion, etc.)			Laser: <input type="checkbox"/> Argon <input type="checkbox"/> CO <sub>2</sub> <input type="checkbox"/> KTP <input type="checkbox"/> YAG <input type="checkbox"/> Holmium
		Blepharoplasty and lid Reconstruction			Lacrimal
		Orbital (Exploratory and simple Repairs)			Enucleation
		Exenteration			Conscious Sedation

I have reviewed the above list and have checked the procedures to which I am limiting my practice; and having been trained accordingly, By my signature below, I certify that my malpractice insurance will cover, to the dollar limits required by the Board of Directors, my exercise of the above requested privileges.

<b>Applicant's Signature:</b>	<b>Date:</b>
-------------------------------	--------------

**DEPARTMENTAL REPORT AND RECOMMENDATION:** Upon review of all the credentialing information available with particular focus on education/training, experience, current competence and ability to perform the specific privileges requested, I recommend the applicant as capable of carrying out duties and is competent to perform each of the specific privileges as designated above.

<b>Signature: Surgery Department Chairman/Vice Chairman</b>	<b>Date:</b>
---	--------------

Date: \_\_\_\_\_  
          Credentials approval

Date: \_\_\_\_\_  
          Medical Executive approval

Date: \_\_\_\_\_  
          Board of Directors approval

**LASER PRIVILEGES**

Current proficiency and knowledge of laser procedures:

- a. Laser surgery course with content consistent with the privileges being requested; or
- b. Letter from a residency director documentation of a training course for the privileges being requested; or
- c. Letter of explanation which requests that these privileges be granted without the above requirements being met.