Huntington Memorial Hospital

Delineation Of Privileges
Ophthalmology Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

OPHTHALMOLOGY PRIVILEGES

Criteria - New Applicants: Board Certification or current participation in the examination process leading to certification by the American Board of Ophthalmology; OR, successful completion of an ACGME or AOA approved training program in Ophthalmology.
Criteria - Current Staff Members Only: Completion of an ACGME or AOA approved training program in Ophthalmology; OR, demonstrated acceptable practice in the privileges requested for a period of five (5) years.
Proctoring Requirements: A minimum of six cases must be proctored, in accordance with the Medical Staff Proctoring Protocol.

GENERAL PRIVILEGES:

Admit patients	___	___	___
Consultation Only Privileges	___	___	___
Surgical Assist ONLY	___	___	___
Sedation Analgesia ***Criteria***: Requires completion of the Sedation Assessment Test	___	___	___
a) Adult Sedation	___	___	___
b) Pediatric Sedation (15 years and under)	___	___	___
CATEGORY 1 - OPHTHALMOLOGY PRIVILEGES: Includes the management and coordination of care, treatment and services, including: medical history and physical examinations; consultations and prescribing medication in accordance with DEA certificate.	___	___	___
Local block anesthesia	___	___	___
Regional block anesthesia	___	___	___
Foreign body removal - cornea, intraocular, scleral, orbital, lids	___	___	___
Repair of various traumatic structures and/or removal - cornea, globe, adnexae, lids, orbit, muscles, vitreous and subchoroidal taps, examination under anesthesia	___	___	___

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Diagnostic procedures - A&B ultrasonography, corneal and conjunctival scrapings, anterior chamber tap, vitreous and subchoroidal taps, examination under anesthesia	___	___	___
Lid surgery, including plastic procedures, chalazion, ptosis, ectropion, entropion, repair of laceration, blepharospasm repair, tumors, flaps	___	___	___
Nasolacrimal duct surgery	___	___	___
Conjunctiva surgery, including grafts, flaps, tumors, pterygium, pinguecula	___	___	___
Intra and extracapsular cataract extraction with or without lens implant, aspiration needling, Kelman phacoemulsification	___	___	___
Corneal surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery	___	___	___
Anterior automated vitrectomy, limbal approach	___	___	___
Strabismus surgery	___	___	___
Glaucoma surgery, including cryotherapy, trabeculectomy, full thickness filtering procedures	___	___	___
Removal of implanted materials - corneal, scleral, intraocular, ocular, orbital	___	___	___
Cryotherapy for retinal tears, photocoagulation by use of laser for retinal tears	___	___	___
Laser capsulectomy, iridoplasty, iridotomy, trabeculoplasty: (ACC)	___	___	___
a) ARGON (ACC)	___	___	___
b) YAG (ACC)	___	___	___
Glaucoma tube	___	___	___
Orbit surgery, including removal of the globe and contents of the orbit, exploration by latreal orbitotomy, exenteration, blowouts, rim repairs, tumor removal, orbital decompression	___	___	___

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Keratoplasty, lamellar or penetrating	___	___	___
Refractive corneal surgery:	___	___	___
a) Radial keratotomy	___	___	___
b) Epikeratophakia	___	___	___
Posterior vitrectomy, including management of tractional retinal detachment, proliferative vitreoretinopathy, endolaser, intraocular gas tamponade, and membrane dissection	___	___	___
Retinal detachment repair involving encircling bands, exoplants, intraocular tamponade	___	___	___
Silicone Oil Injection	___	___	___
Glaucoma surgery for infantile glaucoma including trabeculotomy and goniotomy	___	___	___
Laser treatment for proliferative retinopathies and/or exudative retinopathies	___	___	___
Temporal artery biopsy	___	___	___
OCULOPLASTIC PRIVILEGES ***Criteria:*** Completion of an ACGME or AOA approved Oculoplastic fellowship Program.	___	___	___
a) Cheek Flap Lift	___	___	___
b) Laser resurfacing	___	___	___

Revised: 4/8/2013

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ACKNOWLEDGEMENT OF THE PRACTITIONER:
I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature of Applicant: _____ Date:_____

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section/Department Chair: _____ Date: _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____