Ophthalmology KHDO

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the request checkbox to request a group of privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign/Date form and submit with required documentation.
5. Applicant have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving doubts related to qualification of requested privileges.

NOTE:
Privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Required Qualifications	
Membership	I request the following clinical privileges, and I am aware that a denial of privileges relating to a practitioner's professional competence or professional conduct will result in the hospital submitting a report to the National Practitioner Data Bank.

Primary Privileges Ophthalmology

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request*	Department/Section Chair ☐	Credentials Committee Chair ☐
	Diagnostic Procedures-Examination of Ocular and Related Structures		
☐	Applanation tonometry	☐	☐
☐	Biomicroscopy	☐	☐
☐	Fundus photography	☐	☐
☐	Gonioscopy	☐	☐
☐	Laboratory studies: Cytology, Cultures, Sensitivities, etc.	☐	☐
☐	Ophthalmoscopy--direct/indirect	☐	☐
☐	Retinoscopy	☐	☐
☐	Visual fields studies	☐	☐
	Therapeutic Procedures Involving The Application of Lenses or Orthoptic Therapy for:		
☐	Amblyopia	☐	☐
☐	Anisophoria	☐	☐
☐	Refractive error	☐	☐
☐	Strahisums	☐	☐
☐	Other binocular anomalies	☐	☐
	Therapeutic and/or Cosmetic Application of Contract Lenses		
☐	Cross linked PMMA lenses	☐	☐
☐	Extended wear lenses	☐	☐
☐	Hydrophilic lenses	☐	☐
☐	PMMA lenses	☐	☐
	Low Vision Care		
☐	Microscopic systems	☐	☐
☐	Modified low vision examination	☐	☐
☐	Modified printed material	☐	☐
☐	Telescopic systems	☐	☐
	General Diagnostic Procedures		
☐	Contact lens related services	☐	☐
☐	Comprehensive eye health and vision examination	☐	☐
☐	Diagnostic testing for ocular surface infection	☐	☐
☐	External ocular photography	☐	☐
☐	Gonioscopy	☐	☐
☐	Low vision related services	☐	☐
☐	Noninvasive external diagnostic testing procedures	☐	☐
☐	Non-medical treatment of oculor diseases	☐	☐
☐	Pre and post operative care of ophthalmic surgery patients - under the direction of a Staff Ophthalmologist	☐	☐
☐	Utilization of topical ophthalmic diagnostic pharmaceutical agents (within scope of Ohio license)	☐	☐

☐	Vision therapy/orthoptics related service	☐	☐
	Medication Privileges		
☐	Utilization of topical and oral ophthalmic therapeutic pharmaceutical agents (within scope of Ohio license)	☐	☐
	Medical Treatment of Oculor Diseases		
☐	Epilation of cilia	☐	☐
☐	Puncial dilation	☐	☐
☐	Puncial occlusion - temporary (collagen, silicone plugs)	☐	☐
☐	Removal of superficial non-perforating foreign bodies from cornea and conjectiva	☐	☐
	LASER PROCEDURES OPHTHALMOLOGY		
	Argon		
☐	Coreplasty	☐	☐
☐	Destruction of localized retinal lesion	☐	☐
☐	Destruction of retinopathy	☐	☐
☐	Iridotomy	☐	☐
☐	Iris cyst or lesion	☐	☐
☐	Prophylaxis of retinal detachment without drainage	☐	☐
☐	Trabeculoplasty	☐	☐
	Yag		
☐	Discission of secondary membranous cataract	☐	☐
☐	Incision (needling) of lens	☐	☐
☐	Iridotomy	☐	☐
	Other Privileges/Procedures		
☐	Browpexy	☐	☐
☐	Direct brow lift	☐	☐
☐	FLAP laser suture	☐	☐
☐	Intravitreal injections	☐	☐
☐	Periocular injections	☐	☐
☐	Puncture irrigation	☐	☐
☐	Pterygium	☐	☐
☐	Relaxing incisions	☐	☐
☐	Temporal artery biopsy	☐	☐
☐	Vitreolysis	☐	☐

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at Kettering Health Dayton/Kettering Health Washington Township and I understand that:

A. In exercising any 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 situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature Date

Clinical Service Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

☐	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	Recommend privileges with the following conditions/modifications/deletions (listed below)

Privilege	Condition/Modification/Deletion/Explanation

Clinical Service Chair Recommendation - Additional Comments

Chair, Department/Section Date

Chair, Credentials Committee Date

Submit