CORE SURGICAL PRIVILEGES FORM / OPHTHALMOLOGY

Applicant's Name: ....

License No. (If Any): .... Date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Privileges	For applicant use		For committee use		
	Request	**Signature**	**Recommended**	**Not Recommended**	**Reason for rejection (if any)**
1. Slit lamp eye examination	☐		☐	☐	
2. IOP measurement	☐		☐	☐	
3. Fundus dilatation and examination	☐		☐	☐	
4. Refraction	☐		☐	☐	
5. Removal of conjunctival FB	☐		☐	☐	
6. Removal of corneal FB	☐		☐	☐	
7. Epilation of maldirected eyelashes	☐		☐	☐	
8. YAG laser capsulotomy	☐		☐	☐	
9. Gonioscopy	☐		☐	☐	
10. Chalazion I & C	☐		☐	☐	

Note:

You must submit along with this application all necessary document(s) to support your request.

Applicant's signature .... Date: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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FOR COMMITTEE USE ONLY

Committee Decision:

Evaluation type:

By Interview ☐ virtual / personal

By documents only ☐

Or both ☐

Other comments:

....

We have reviewed the requested clinical privileges and supporting documentation for the above-named applicant, and We have made the above-noted recommendation(s).

Clinical privileging committee members:

....
Name, Signature & Stamp

Date: ☐☐ ☐☐ ☐☐☐☐

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Name, Signature & Stamp

Date: ☐☐ ☐☐ ☐☐☐☐

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