Surgical Privileges Form: Ophthalmology Clinical Privileges Request

(Advanced Privileges/for Specialty Only)

Applicant's Name: …… Scope of Practice: ……

License No. (If Any): …….. Facility: ……..

Date: ……..

Instructions

For applicant:

1. **Please note that you should sign next to each requested privilege.**
2. **Please use this sign (√) for the requested privilege.**
3. **Please leave any procedures you do not want to apply for blank and do not use (X) sign.**
4. **Please do not write additional privilege out of your scope of practice, as it will not be accepted.**
5. **Please do not write anything in the "for committee Use "section.**
6. **For additional privilege, do not choose the already granted privilege.**
7. **Please attach the previous approval of surgical privilege when you apply for additional privilege.**
8. **Please note that you can apply for Appeal within one month of the date of Issuance of the Privilege.**
9. **You can only apply Once for Appeal per a single Privilege Application.**

For committee:

1. **Please note that the final decision must be signed by minimum 2 committee members.**
2. **Please use this sign (√) for recommended and not-recommended privilege.**
3. **Please note that granting privileges under supervision is not permitted. Please do not write "under supervision" note next to any privilege.**
4. **Please specify the reasons for rejection (if applicable); for example (require experience, logbook is insufficient, need additional courses, etc.)**

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CATEGORY I: OPHTHALMOLOGY PROCEEDURES (Anterior Segment Section)

Privileges	*For applicant use*		*For committee use*		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Cataract operation					
a. Phacoem ulsification+ IOL					
b. ECCC+IOL					
c. Irrigation & Aspiration± Ant.vitrectomy±IOL					
2. 2nd Implantation					
a. Ant.IOL					
b. Post.IOL					
3. Keratoplasty					
a. Pentrating keratoplasty					
b. Lamellar keratoplasty					
4. Glaucoma					
a. Trabeculectomy + Mytomycin C					
b. Trabeculectomy					
c. Deep sclerectomy					
d. Goniotomy					
e. Trabeculotomy					
5. Cyclo-cryopexy					
6. Cyclophotocoagulation					

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Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
7. Iris Surgery					
a. Iridectomy					
b. Iris Lesion Excision					
8. YAG Laser Capsulotomy					
9. Laser Iridectomy					
10. Superficial Keratectomy					
11. Conjunctival lesion excision biopsy					
12. Examination under anesthesia					
13. Eye trauma repair					

CATEGORY II: OPHTHALMOLOGY PROCEEDURES (Posterior Segment Section)

Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
1. Scleral buckling for retinal detachment					
2. Pars plana vitrectomy for					
a. Diabetic vitreous he or tractional retinal detachment					

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Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
b. Macular hole surgery with internal limiting membrane removal					
c. Proliferate vitreo retinopathy with or without anterior retinectomy					
d. Endophthalmitis					
e. Removal of sub retinal hemorrhage					
f. Removal of intra-ocular foreign body					
g. Removal of dropped nucleus or IOL					
3. Pars plana Lensectomy					
4. Anterior vitrectomy					
5. Intravitreal injection of:					
a. Antibiotic					
b. Triamicnolon/Avastin/Lucentis					
c. Expansile gases(pneumatic retinopathy)					
6. Silicon oil injection or intravitreal injection of gases					
7.Silicon oil removal					
8. Cryopexy					
9. Indirect Laser					
10.Cyclo-Photocoagulation					
11.Argon Laser					

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Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
a. Panretinal laser photocoagulation					
b. Focal laser photocoagulation					
c. Grid Laser					
12.Phaco or ECCE + PPV					
13.Phaco + silicon oil removal					
14.Phaco + IV injection					
15.EUA for pediatric retina					
16.Eye trauma repair					

CATEORGY III: OCULOPLASTIC PROCEDURES

Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1.Everting sutures,horizontal lid shortening					
a. For Entropion & Triciasis lower lid					
b. For Ectropion of upper lid					
2. Tarsal fracture					
3. Tarsorraphy – for facial pulsy					
4. Levator resection for ptosis					
5. Brow suspention for ptosis					
6. Eyelid tumor excision					
7. DCR+ intubation for dacryocystitis					

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Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
8. Dermoid and lipodermoid excision					
9. Enucleation and implant					
10.Evisceration and implant					
11. Blepharoplasty					
12.Eye trauma repair					
13.Probing and intubation					
14.Pterygium and Autograft					
15.Chalazion I & C					

CATEGORY IV: PEDIATRIC OPHTHALMIC SURGICAL

Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
1. Strabismus					
a. Horizontal muscle recession+ resection					
b. horizontal muscle tendons transposition					
c. Vertical muscles adjustable suture, recession and resection					
d. Vertical muscle recession, resection and faden sutures					

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Privileges	*For applicant use*		*For committee use*		
	Request	***Signature***	***Recommended***	***Not Recommended***	***Reason for rejection (if any)***
e. Oblique muscles myectomy, recession and transposition					
2. Congenital and traumatic cataract					
a. Lensectomy and anterior vitrectomy					
b. Phaco emulsification & primary IOL implant					
c. Secondary IOL implant					
d. Secondary IOL implant with scleral fixation					
3. Congenital glaucoma					
a. Goniotomy					
b. Trabeculoctomy with & without mitomycin C					
4. Oculoplatic					
a. Probing of nasolacrimal					
b. Probing and intubation of nasolacrimal duct					
c. Dermoid cyst excision (limbal, angular)					
d. Congenital lid and anterior segment tumors excision					
5. Anterior segment					
a. Iris surgery (iridectomies, congenital iris tumor excision)					

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	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
b. Pupiloplasty (congenital anterior papillary membrane reminants and adhesions, post traumatic pupil reconstruction)					
6. Examination under anesthesia					
7. Eye trauma repair					

CATEGORY V: Additional Privileges (not included above)

Privileges	*For applicant use*		*For committee use*		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1.					
2.					
3.					
4.					
5.					
6.					

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Notes:

- If additional privilege(s) are desired, please indicate this in the space provided above.
- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- Granting privileges under supervision is no longer permitted

By signing below, I acknowledge that I have read, understand, and agree to abide by DHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by DHP's 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 recognized policies and rules.

…….. ……

Applicant's signature (Stamp if any) Date

…….. ……

Medical Director (of the facility the applicant will perform surgeries in) Stamp & 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:

……

Evaluation Committee Chairman:

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

…….. ……

Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……

1) Name Date

…….. ……

2) Name Date