



**CORE PRIVILEGES**  
Ophthalmology Services

**QUALIFICATIONS:**

- MD or DO with successful completion of an accredited ACGME or AOA residency in ophthalmology
- Current certification or active participation in the examination process leading to certification in ophthalmology by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology
- Documentation or attestation of current clinical practice experience with at least 100 ophthalmologic surgical inpatients or outpatients within the past 24 months as attending physician. *Reappointments: please be prepared to provide a list of cases performed at facilities other than Teche Regional Medical Center if requested.*

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		<b>CORE PRIVILEGES:</b>				
		Privileges to admit to outpatient services, evaluate, diagnose, consult, and provide surgical and non-surgical care to patients of all ages presenting with illnesses, injuries and disorders of the eye, including its related structures and visual pathways. Privileges include use of local anesthetics and parenteral sedation for ophthalmologic condition, phacoemulsification of cataracts, and insertion of intraocular lens.				
		Core privileges further include the provision of inpatient consultations, as well as the ordering of diagnostic studies and procedures related to ophthalmologic problems.				
		Surgical procedures include, but are not limited to the following: <ul style="list-style-type: none"> <li>• Surgery of the eye and adnexa; cornea, iris, lens extraction, IOL insertion, vitreous, retina, orbit, lids, lacrimals</li> <li>• Removal of superficial foreign bodies</li> <li>• Surgery Techniques needed for trauma/ emergency care</li> <li>• Enucleation</li> <li>• Retrobulbar injection</li> <li>• Dilation of lacrimal puncta</li> </ul>				
		<b>SPECIAL PROCEDURES:</b> documentation of actual case experience within the past 2-years; evidence of formal training and/or additional course work				

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center, and attest that I meet the minimum qualifications and have performed 100 ophthalmologic procedures or more over the past 24-months.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Requested privileges reviewed and recommended as indicated above.

\_\_\_\_\_  
Signature of Service or Department Chair

\_\_\_\_\_  
Date

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**Board of Trustees' Decision**

*Teche Regional Medical Center's Board of Trustees*

**Does**

**Does not grant clinical privileges as requested**

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

\_\_\_\_\_  
Secretary, Board of Trustees

\_\_\_\_\_  
Date



**HEALTH STATEMENT**

**TO CHIEF OF SERVICE / CHIEF OF STAFF**

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES  NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES  NO

If yes, please explain:

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3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST?  YES  NO

If yes, please give date of positive skin test. \_\_\_\_\_

If no, when was your last PPD test? \_\_\_\_\_

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF OF SERVICE

\_\_\_\_\_  
DATE