

**CARLSBAD MEDICAL CENTER
APPLICATION FOR CLINICAL PRIVILEGES
DEPARTMENT OF SURGERY: OPHTHALMOLOGY**

NAME: _____ DATE: _____

Life threatening emergency: At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

Criteria for requesting privileges include significant training in and experience in the care of these conditions requiring skills usually achieved only during training sufficient to attain **eligibility for board certification.**

Requested	Granted	
___	___	All operations on lacrimal apparatus, eyelids, conjunctiva, ocular muscles, on/in orbit
___	___	Enucleation
___	___	Suture/repair of eyeball
___	___	All operations of cornea
___	___	All operations in iris, lens, anterior segment
___	___	All operations on vitreous, choroid and retina
___	___	Foreign body removal
___	___	Cryocoagulation
___	___	Photocoagulation
___	___	Local anesthesia
___	___	Nerve block anesthesia (diagnostic-therapeutic)
___	___	Biopsy of eye and adenxae
___	___	Lens implant
___	___	Conscious sedation

Illness or problem requiring an unusual degree of expertise or competence in techniques requiring special skills, usually acquired only with experience or subspecialty training. Board certified in subspecialty requested, or Board qualified within the current time limits of the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology.

* Those privileges marked with an * require documentation of training and/or experience in addition to board Certification or qualification in the requested subspecialty.

** Privileges not listed below will not be granted until the development of procedure specific criteria.

Requested	Granted	
___	___	*Radial keratotomy
___	___	*Phaco emulsification
___	___	*Indirect Diode Laser Treatment
___	___	*Epikeratophakia
___	___	** _____
___	___	** _____

APPLICANT'S SIGNATURE: _____ DATE: _____

Specific privileges denied: ___ ___
Yes No

If yes, please comment: _____

REVIEWED BY: _____

TITLE: _____ DATE: _____

Procedure	Accredited Course with Practice Eyes	Accredited Course with Hands on Laboratory
Radial Keratotomy	X	
Phaco Emulsification		X
Indirect Diode Laser Treatment		X
Epikeratophakia	X	



AUTHORIZATION FOR BACKGROUND CHECK

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

Print Name

Signature

Date