

Loma Linda University Medical Center
Loma Linda, CA 92354

PRIVILEGE FORM

CLINICAL AREA: **OPHTHALMOLOGY**

Name: _____

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REQUEST	CATEGORY	MEMBERSHIP CATEGORY	ACTION		
			Approved	Conditions	Denied
	Provisional (Bylaws 4.3)	All initial appointees shall be placed in the Provisional Category for the duration of their initial appointment.			
	Administrative (Bylaws 4.7)	For practitioners who are members of the Medical Staff who have no clinical privileges, who are recommended for appointment or reappointment to the Administrative Staff by the Chief of the Clinical Service, the Credentials Committee, and the Medical Staff Executive Committee, and who must MUST meet the following:			
		1. Have been a member in good standing of the Active, Courtesy, or Provisional Staff for at least one (1) year.			
		2. Have completed proctoring for any clinical privileges previously requested.			
		3. Agree to refrain from participating in any activities within the Medical Center that require clinical privileges.			
		4. Provide significant service to the Medical Center and the Medical Staff in the form of academic activities, quality improvement activities, or administration.			
		5. Be recommended for appointment or reappointment			
		Failure to meet any of these qualifications will be adequate grounds to deny reappointment.			
	Affiliate (Bylaws(4.9)	Practitioners who CANNOT : 1. Vote or hold office in the Medical Staff or Service. 2. Be a member of any Medical Staff Committee. 3. Be Reappointed to the Affiliate Category.			
		Practitioners who MUST : 1. Have been a member in good standing of the Active, Courtesy or Consulting category during the immediate preceding appointment period. 2. Have completed, in a timely manner as described in the Bylaws, an application for reappointment. 3. Have been found to be qualified for reappointment, other than the volume of clinical activity.			
	Active (Bylaws 4.2)	Regularly care for patients in the Medical Center; have completed proctoring requirements and the Provisional period.			
	Courtesy (Bylaws 4.4)	Admit or otherwise provide care for not more than twelve (12) patients in the Medical Center during each year. Have completed proctoring and the Provisional period.			
	Consulting (Bylaws 4.5)	Render a clinical opinion within their competence. Shall not be eligible to admit patients or to assume continuing care of patients in the Medical Center. Not eligible to vote or hold office in the Medical Staff or Clinical Service			

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CATEGORY	QUALIFICATIONS
All	Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested for patients of all age groups, except as specifically excluded from practice; and one of the following:
Category 1	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 and Otorhinolaryngology to be achieved within five (5) years of completion of residency training; or Successful completion of an ACGME/AOA accredited residency program in ophthalmology and acceptable practice in the privileges requested for at least an additional three (3) years.
Category 2	As stated above for Category 1, plus: Formal supervised training (approved fellowship) or clinical experience of sufficient breadth and length with acceptable results. 2a Approved Oculoplastic/Orbital/Neuro-ophthalmology fellowship or clinical experience with proved acceptable results. 2b Approved/recognized Cornea fellowship or clinical experience with proven acceptable results. 2c Approved/recognized Surgical Vitreoretinal fellowship or clinical experience with proved acceptable results. 2d Approved/recognized Pediatric Ophthalmology fellowship or clinical experience with proven results
Laser	As stated above for Category 1, plus at least one of the following: A. ABO certification with proven acceptable results. B. Approved Glaucoma fellowship and/or demonstrated competence. C. Approved Vitreoretinal fellowship
Observation Requirements	As specified in the Ophthalmology Service rules and regulations.
Sedation	Moderate Sedation: Successful completion of the PURPLE Book test, or equivalency, from Loma Linda University Medical Center – Quality Resource Management (LLUMC-QRM). Deep Sedation: Successful completion of the PRS Self-Study packet and test, or equivalence, from LLUMC-QRM.

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MARK IF REQUESTED	CODE	PRIVILEGE	ACTION		
			Approved	Conditions	Denied
GENERAL					
	OPH00300	Admit, treat, consult on ophthalmologic disease/disorders/conditions			
	OPH00301	Consult on ophthalmologic disease/disorders/conditions			
		Supervision of Residents and Students			
		Supervision of Allied Health Professionals under the following circumstances: AHP is granted practice privileges by the Medical Staff AHP operates under standardized procedures Other circumstances as recommended by the IDP Committee and approved by the Medical Staff			
		Supervise Radiologic Technologists and operate Fluoroscopy Equipment. <u>Fluoroscopy Supervisor and Operator Permit required</u> (attach current copy).			
CATEGORY 1					
	OPH00650	Lid surgery, including plastic procedures, chalazion, ptosis, ectropion, repair of laceration, blepharospasm repair, tumors, flaps, enucleation, evisceration			
	OPH08240	Nasolacrimal duct surgery			
	OPH02590	Conjunctiva surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery			
	OPH06110	Intra and extracapsular cataract extraction with/without lens implant, or phacoemulsification			
	OPH02650	Corneal surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery			
	OHP00800	Anterior automated vitrectomy, limbal approach			
	OPH11830	Strabismus surgery			
	OPH08320	Neuro-ophthalmology			
	OPH10400	Primary trabeculectomy surgery (glaucoma)			
	OPH02930	Cryotherapy for retinal tears			
	OPH11280	Retinal detachment repair			
	OPH08902	Orbit surgery including removal of the globe, exenteration blow outs, rim repairs, tumor removal			
	<u>OPH10680</u>	<u>Refractive surgery</u>			
	OPH04860	Glaucoma surgery with intraoperative/postoperative antimetabolite therapy			
	OPH04850	Glaucoma Seton/Tube surgery			
	OPH04840	Glaucoma reoperation			

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MARK IF REQUESTED	CODE	PRIVILEGE	ACTION		
			Approved	Conditions	Denied
CATEGORY 2a					
	OPH08900	Orbit surgery, including removal of the globe and contents of the orbit, exploration by lateral orbitotomy, exenteration, blowouts, rim repairs, tumor removal			
CATEGORY 2b					
	OPH06440	Keratoplasty, lamellar or penetrating			
	OPH04010	Epikeratophakia			
CATEGORY 2c					
	OPH10260	Posterior vitrectomy, including management of tractional retinal detachment, proliferative vitreoretinopathy, endolaser, intraocular gas tamponade, and membrane dissection			
	OPH11280	Retinal detachment repair involving encircling bands, exoplants, intraocular gas tamponade			
CATEGORY 2d					
	OPH04860	Glaucoma surgery for infantile glaucoma including trabeculotomy and goniotomy			
USE OF LASER					
<i>Use limited to approved applications for the specific laser indicated. List and check "Yes" in the Requested column for each specific type of laser for which privileges are requested.</i>					
LASER A					
Requires ABO certification with proven acceptable results					
	OPH06611	Argon Laser Peripheral Iridotomy			
	OPH06612	Argon Laser Trabeculoplasty			
	OPH06613	Argon Laser Pupilo/Gonioplasty			
	OPH06614	Argon Laser Suture Lysis			
	OPH06615	YAG Laser Peripheral Iridotomy			
	OPH06616	YAG Laser Capsulotomy			
LASER B					
Requires approved Glaucoma fellowship and/or demonstrated competence.					
	<i>Laser A plus:</i>				
	OPH06621	YAG Laser Cyclophotocoagulation			
	OPH06622	YAG Laser Trabeculoplasty			
	OPH06623	YAG Laser Sclerostomy Lysis			

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			Approved	Condition	Denied
LASER C					
Requires Approved Vitreoretinal fellowship					
		Laser A <i>Plus</i> :			
	OPH06631	Argon Laser Pan-retinal Photocoagulation			
	OPH06632	Argon laser Macular Photocoagulation			
SEDATION					
	OPH99998	Moderate sedation			
	OPH99999	Deep sedation			

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Acknowledgment of Practitioner

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Loma Linda University Medical Center, Inc.; **and**

I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by any 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.

Signed: _____

Date: _____

**** *For Hospital and/or Clinic Use Only* ****

Conditions/Modifications:

The requested clinical privileges have been approved by the Board of Trustees with the following conditions/modifications and the explanation for same.

Code	Privilege	Condition/Modification
Code	Explanation:	

 Chief of Service

 Date

 Credentials committee

 Date

 Medical Executive Committee

 Date

 Approved By Governing Body

 Date