

MILLARD FILLMORE SURGERY CENTER, LLC

Name _____

Date _____

DELINEATION OF PRIVILEGES - OPHTHALMOLOGY

Credentialing period effective for 2 years

<u>LEVEL I (CORE) PRIVILEGES</u> <i>Core privileges are those that can be performed after successful completion of an accredited residency program in Ophthalmology.</i>	<u>LEVEL I (CORE) PRIVILEGES (CON'T)</u>
EYELIDS:	GLOBE:
Biopsy	Astigmatic keratotomy
Blepharoplasty for redundant skin or herniation of orbital fat through orbital septum	Anterior vitrectomy (including pars plana)
Blepharorrhaphy, tarsorrhaphy, canthoplasty	Cataract extraction: intracapsular, extracapsular, phacoemulsification
Chalazions	Excision, lesion of iris, malignant or non-malignant
Excision of nevus, papilloma, tumors	Intraocular lens implantation and removal
Lid lacerations, reconstruction and plastic repair	Muscle operation for squint
Lid margin lesion, benign or malignant; block excision & plastic repair with graft	Paracentesis, treatment or diagnosis, aspiration
Ptosis, plastic correction: levator resection/Illif or similar method	Pterygium, excision
Entropion or ectropion, plastic repair, muscle or tarsal resection or imbrication with graft (cicatrical)	Repair of wound for flat anterior chamber
CONJUNCTIVA:	Removal of foreign body
Biopsy	Repair of iridodialysis
Conjunctivoplasty: free graft with conjunctiva	Secondary lens implantation
Excision of lesion	GLAUCOMA:
Flap operation for ulcer, perforation of operative wound	Intraocular surgery for glaucoma, peripheral iridectomy and filtering
Suture of conjunctiva for laceration	Trabeculectomy (with use of antimetabolites)
REPAIR/REVISION:	LACRIMAL:
Excision lesion, cornea	Closure, lacrimal punctum
Repair of iris, ciliary body	Probe, nasolacrimal duct
Suture of iris, ciliary body	INJECTIONS:
Repair or revision of operative wound	Anterior chamber
Revision of aqueous shunt	Intravitreal
OTHER:	Retrobulbar
Administration of local anesthesia	Subconjunctival
Aqueous shunt	Sub-tenon
History & Physical	
Strabismus	

<u>LEVEL I (CORE) PRIVILEGES</u>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)

<u>LEVEL II PRIVILEGES</u>	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)
Muscle Transposition (Vertical & Oblique) <i>(Two satisfactory cases performed under supervision of an ophthalmologist with privileges for this procedure)</i>				

LEVEL II PRIVILEGES	PHYSICIAN REQUEST	Granted	Not Granted*	With Following Requirements** (Provide Details)
Penetrating Keratoplasty <i>(Two satisfactory cases performed under supervision of an ophthalmologist with privileges for this procedure or approval from Program Director with certified list of at least five monitored successful cases or completion of a Corneal Fellowship)</i>				
Endothelial Keratoplasty <i>(Two satisfactory cases performed under supervision of an ophthalmologist with privileges for this procedure or approval from Program Director with certified list of at least five monitored successful cases or completion of a Corneal Fellowship)</i>				
Amniotic Membrane Transplantation <i>Two satisfactory cases performed under supervision of an ophthalmologist with privileges for this procedure or approval from Program Director with certified list of at least five monitored successful cases or completion of a Corneal Fellowship)</i>				

KEY	*NOT GRANTED DUE TO: Provide Details Below	**WITH FOLLOWING REQUIREMENTS Provide Details Below
	1) Lack of Documentation	1) With Consultation
	2) Lack of Required Training/Experience	2) With Assistance
	3) Lack of Current Competence (Databank Reportable)	3) With Proctoring
	4) Other (Please Define) (i.e., Exclusive Contract)	4) Other (Please Define below)

DETAILS: _____

National Practitioner Databank Disclaimer Statement:

Kaleida Health must report to the National Practitioner Data Bank when any clinical privileges are not granted for reasons related to professional competence or conduct. (Pursuant to the Health Care Quality Improvement Act of 1986 (43 U.S.C. 11101 et seq.)

_____/_____
Signature of Applicant **Date** _____/_____
Signature of Clinical Chief **Date**

APPLICANT: PLEASE RETAIN A COPY OF THIS SIGNED DELINEATION FOR YOUR RECORDS