

# OPHTHALMOLOGY PRIVILEGE FORM

NAME: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_ To \_\_\_\_\_

**LEGEND:** 1 – BMC - Jax      2 – BMC - Beaches      3 – BMC - Nassau      4 – SV Southside      5 – SV Riverside  
6 – UF Jax/UF TCU      7 – Wolfson      8 – Brooks      9 – BMC - South      10 – SV Clay

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	CORE PRIVILEGES	APPR
										Work-up, admission, assessment, history and physical examination, diagnosis, consultation, and surgical or non-surgical treatment of patients with illnesses, injuries and disorders of the eye, and related structures. Includes phacoemulsification. [Physicians desiring privileges for children <24 months at Wolfson must complete the Pediatric Ophthalmology Privilege Form]	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request for the privilege along with documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES	APPR
										Procedures that may not be part of residency/fellowship training, and/or may require additional proof of training or experience.	
										Lamellar Keratoplasty [++Hospital 6]	
										Laser - Please list type(s): _____ [++Hospitals 1, 2, 4, 5, 6, 7]      [CO <sub>2</sub> , nd: YAG, Diode]	
										Macular Photocoagulation [++Hospitals 1, 5, 6, 12]	
										Moderate Sedation [++Hospitals 1, 2, 3, 4, 5, 6, 7, 9]	
										Penetrating Keratoplasty [++Hospitals 6]	
										Placement of External Radiotherapeutic Source [++Hospitals 1, 2, 6]	
										Removal of Intraocular Foreign Body, Posterior [++Hospitals 1, 7]	
										Vitrectomy, Posterior [++Hospitals 1, 6, 7]	

**Acknowledgment of Practitioner:** I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff policies, rules and regulations, and (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 each hospital's Medical Staff Bylaws.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

■ Privilege not available in this specialty at this hospital.  
 ++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.  
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