

OPTOMETRIST PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 – BMC - Jax 2 – BMC - Beaches 3 – BMC - Nassau 4 – SV Southside 5 – SV Riverside
6 – UF Health Jax 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
										Assessment and examination of the eye, orbit, adnexa, and anterior and posterior segments, including case history, consultation and ordering of medical tests to determine diagnosis (e.g. cultures, blood work, x-rays, CT scans, MRI)	
										Eye treatment including prescription of lenses, prisms, low-vision aids, etc. and prescription/administration of topical ophthalmic medication in accordance with Florida law.	

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 Procedures that are not routinely part of training, and may require proof of training or experience.	APPR
										Use of Retinoscopy to Determine Refractive Status	
										Use of Biomicroscopy for External Ocular Health Exam	
										Use of All Types of Tonometers in Conjunction with Local, Topical Anesthesia to Determine Intraocular Pressure	
										Fundoscopic Examination Utilizing 3-Mirror Goldmann Fundus and Gonioscopic Lenses, in Conjunction with Mydratic or Cycloplegic Pharmaceuticals	
										Visual Field Exams Utilizing Standard Perimetry	
										Anterior Segment Foreign Body Removal Utilizing Alger Brush or Needle or Spud	

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:** _____

Sponsoring Physician 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.