

Regions Hospital Delineation of Privileges Ophthalmology

Applicant's Name: _____
Last
First
M
Date

Instructions: Applicants must provide complete names and addresses for their references. Please DO NOT SEND letters of recommendation along with your application. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

CORE I- Privileges Ophthalmology (Medical Only)

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admission and work-up of patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways. These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problem. These privileges do not include any of the special requests listed under the section entitled "Special Requests for Privileges in Ophthalmology".</p>	<ol style="list-style-type: none"> 1. MD, DO, OD, MBBS 2. Successful completion of an ACGME, AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency program in Ophthalmology or Optometry. 	<p><u>New Applicants:</u> Names and addresses of two (2) Ophthalmologists whom we may contact who can comment on your current clinical competence. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p><u>Reappointment Applicants:</u> Must supply documentation of numbers of procedures performed during the past 24 months, or Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p>

CORE II- Privileges Ophthalmology (Medical and Minor Surgical)

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admission and work-up, and performance of minor surgical procedures (those done in an office setting) on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways. These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problem. These do not include any of the special requested listed under the section entitled "Special Requests for Privileges in Ophthalmology".</p>	<p>Same as Core I</p>	<p><u>New Applicants:</u> Names and addresses of two (2) Ophthalmologists whom we may contact who can comment on your current clinical competence. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p><u>Reappointment Applicants:</u> Must supply documentation of numbers of inpatient services performed during the past 24 months, or Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. Name: _____ Add: _____ Ph/Fax#: _____</p>

CORE III- Privileges Ophthalmology (Medical and Surgical)

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admission and work-up, and performance of surgical procedures on patients of all ages presenting with illnesses, injuries, and disorders of the eye, including its related structures and visual pathways. These privileges include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the ophthalmologic problem. These do not include any of the special requested listed under the section entitled "Special Requests for Privileges in Ophthalmology".</p>	<p>Same as Core I</p>	<p><u>New Applicants:</u> Names and addresses of two (2) Ophthalmologists whom we may contact who can comment on your current clinical competence. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p>Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p> <p><u>Reappointment Applicants:</u> 1. Must supply documentation of numbers of inpatient services performed during the past 24 months, or 2. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Ph/Fax#: _____</p>

CORE IV- Special Privileges Ophthalmology

Procedures	Basic Education	Minimal Formal Training
<input type="checkbox"/> Yag Laser	Same as Core I for all privs below	1. Successful completion of an approved residency training program in Ophthalmology.
<input type="checkbox"/> Argon Laser		1. Successful completion of approved residency-training program in Ophthalmology.
<input type="checkbox"/> Penetrating & Lamellar Keratoplasty		1. Successful completion of approved residency-training program in Ophthalmology. 2. Successful completion of a Corneal fellowship.
<input type="checkbox"/> Radial Keratotomy		1. Successful completion of approved residency-training program in Ophthalmology. 2. Successful completion of a corneal fellowship, or 3. A course on Radial Keratotomy, or 4. A letter from a residency Director documenting previous experience.
<input type="checkbox"/> Epikeratophakia		1. Successful completion of approved residency-training program in Ophthalmology. 2. Successful completion of a Corneal fellowship.
<input type="checkbox"/> Photorefractive/Therapeutic Keratectomy and LASIK (PTK and PRK).		1. Successful completion of approved residency-training program in Ophthalmology. 2. Successful completion of a corneal fellowship, or 3. A course on PRK and PTK, or 4. A letter from a residency Director documenting previous experience.
<input type="checkbox"/> Other		

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

Signature

Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Signature

Date