


































**AMBULATORY SURGERY DIVISION
REQUEST FOR PRIVILEGES
OPHTHALMOLOGY**

Name: _____ Date: _____

The minimum education, training and experience qualifications for Medical Staff membership are delineated in the Medical Staff Bylaws, Rules and Regulations and/or Policies and Procedures of each facility. Please consult these documents prior to requesting privileges.

 Indicates privilege that is not available in this specialty at this facility.

To request privileges, please place an "X" in the appropriate facility column.

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Cataract Extraction		
				Cataract Extraction with IOL Implant		
				Cataract Extracton with IOL Implant with Phacoemulsification		
				Chalazion		
				Congenital Glaucoma Surgery		
				Corneal Transplant		
				Correcton of Ectropian & Entropian		
				Correcton of Epiblepharon		
				Crawford Tube Procedure with/w-out Infracture of Inferior Turbinates		
				Cunjunctival Biopsy		
				Cunjunctival Flap		
				Cyclocryopexy		
				Cyst, Excision		
				Discission		
				Enucleation		
				Evisceration		
				Exam Under Anesthesia (EUA)		
				Excision of Dermoid, Globe or Orbit		
				Exploration of the Orbit		
				Faden Procedure		
				Filtering Glaucoma Surgery		
				Goniotomy		
				Iridectomy		
				Iridoplasty		
				IV Conscious Sedation		
				Keratorefactory Surgery		

Bailey Square Surgery Center	Oakwood Surgery Center	Surgicare of South Austin	North Austin Surgery Center	Description of procedures for which privileges are requested:	Approved	Denied
				Lacrimal Duct Probing with/without Infracture of Inferior Turbinates		
				Lacrimal Dacryocystorhinostomy		
				Muscle Operation, Recess/Resect		
				Muscle Operation with & without Adjustable Suture		
				Muscle Transposition Procedure		
				Oculinum Injection		
				Peripheral Iridectomy		
				Photocoagulation		
				Pterygium / Superficial Lamellar Keratectomy		
				Ptosis Correction Eyelids		
				Removal Foreign Body		
				Repair Orbital Floor Fracture		
				Repair Traumatic Corneoscleral Laceration		
				Retinal Cryopexy		
				Retinal Surgery Including Scleral Buckle and Vitrectomy		
				Roto Extraction Cataract		
				Trabeculectomy Ab Externo		
				Vitrectomy		
				Reads own xray/xray images (must make note of findings in op report)		

If the condition/privilege you are interested in is not included on this form, please provide a separate written request and appropriate documentation of training and/or experience.

Based upon my training and experience, I hereby request privileges in the specialty of Ophthalmology, as shown on this form. I understand that privileges granted to me may differ from those requested. I further understand that the completion of this form does not preclude me from requesting additional privileges in the future.

In exercising the privileges granted to me, I agree to strictly abide by the facility's Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures. I acknowledge that any restrictions on the clinical privileges granted to me are waived in an emergency/disaster situation, and in such a situation, my clinical privileges will be governed by the facility's Medical Staff Bylaws and Rules and Regulations.

Applicant's Signature & Date

DEPARTMENT RECOMMENDATION

I have reviewed the applicant's credentials and request for the above privileges. The following recommendations are made:

___ APPROVED ___ DENIED ___ DEFERRED ___ OTHER: _____

Department Chairperson's Signature & Date

GOVERNING BOARD APPROVAL

Approval Date per Minutes: ____/____/____
(Privileges expire two years from Approval Date.)