DELINEATION OF PRIVILEGES
PRACTICE AREA: **OPHTHALMOLOGY**

To request these clinical privileges, the following threshold criteria must be met:

1. Licensed by the State of Iowa as M.D. or D.O., **AND**

2a. Board Certification by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology and Otolaryngology with certification in ophthalmology, **OR**

2b. Successful completion of an ACGME or AOA accredited residency program in ophthalmology **WITH** board certification in 5 years or less of residency completion. **AND**

3. Maintain admitting ophthalmology privileges at one of the UnityPoint Health-Des Moines Hospitals, one of the Mercy Health Network-Des Moines Hospitals, VA Central Iowa Health Care System or Broadlawns Medical Center. Surgeons with VA privileges only will be limited to schedule adult patients only at the center.

OPHTHALMOLOGY SURGERY PRIVILEGES - I am requesting ophthalmology surgery privileges for:

Requested	Granted	
□	□	Correct or treat various conditions, illnesses, and injuries and disorders of the eye, including its related structures and visual pathways, excluding cataract surgery
□	□	Excision of lesions, chalazion
□	□	Strabismus surgery
□	□	Repair / Revise eyelid or eye socket would or defect
□	□	Removal of extraoccular foreign body
□	□	Revision of eye muscles
□	□	Tear duct system surgery
□	□	Administration of local anesthesia
□	□	Administration of minimal sedation
□	□	Supervision of Allied Health Practitioner/Residents/Students

To admit patients, perform histories and physicals, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during medical school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility.

You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

_____ _____

Date Applicant's Signature

_____

Applicant's Name Printed

Privileges:

Granted _____ Deferred _____ _____

MEC Signature **Date**

Granted _____ Deferred _____ _____

GB Signature **Date**

Modifications: _____