

University of Utah Hospitals and Clinics
Delineation of Privileges
OPHTHALMOLOGY

Applicant Name: _____ Date: _____

- Initial Appointment Reappointment

Eligibility criteria: To be eligible for privileges in ophthalmology, the applicant must meet the following minimum threshold criteria:

1. MD, DO degree or foreign equivalent
2. Successful completion of an ACGME accredited residency program in ophthalmology
3. Board certification or active participation in the examination process by the American Board of Ophthalmology
2. Valid, unrestricted Utah physician license

OPHTHALMOLOGY CORE PRIVILEGES

Please cross out any privilege that you are unable to perform or do not wish to request.

Core privileges include admission, evaluation, diagnosis, consultation and surgical as well as non-surgical care of ophthalmology patients of all ages to correct or treat illnesses, injuries and disorders of the eye including its related structures and visual pathways and includes the use of local anesthetics, phacoemulsification of cataracts, and insertion of intraocular lenses. Core privileges do not include the special procedures listed below.

Special Procedures:

All special procedures require documentation of current clinical competence, e.g., training documentation, recent case logs, etc. Applicants must have completed a specialized ophthalmology fellowship and provide documented experience performing the special procedures requested.

- _____ Lamellar Keratoplasty
- _____ Penetrating keratoplasty
- _____ Keratoprosthesis implant and refractory surgery
- _____ Trabeculectomy
- _____ Trabeculotomy
- _____ Goniotomy or drainage valve procedures

- _____ Pars plana posterior capsulectomy
- _____ Intraoperative photocoagulation
- _____ Cryotherapy
- _____ Vitreoretinal membrane peeling
- _____ Excision of choroidal tumor
- _____ Excision of ciliary body tumor
- _____ Transposition of extraocular muscles
- _____ Chemodenervation of extraocular muscles
- _____ Adjustable strabismus surgery
- _____ Interposition of muscle expander
- _____ Recession, resection, advancement, myotomy, myectomy or tuck of vertical extraocular muscles
- _____ Orbitotomy requiring bone flap
- _____ Exenteration of orbit
- _____ Repair of orbital fracture
- _____ Removal of eyelid tumor requiring skin graft
- _____ Ptosis surgery
- _____ Reconstructive lid surgery – blepharoplasty – upper and lower
- _____ Removal of optic nerve tumor
- _____ Optic nerve decompression
- _____ Conjunctival mucosal graft
- _____ Dacryocystorhinostomy
- _____ Removal of lacrimal gland tumor

- _____ Forehead and brow lifts
- _____ Midface lifts
- _____ Facial rejuvenation
- _____ Laser to face
- _____ Microdermabrasion or dermabrasion to face
- _____ Scar revision
- _____ Primary and secondary orbital and socket reconstructive surgery
- _____ Free fat and dermis fat grafts
- _____ Skin grafts and skin flaps
- _____ Bone grafts
- _____ Osteotomies
- _____ Lipotransfer
- _____ Myocutaneous flaps
- _____ Temporal artery biopsy
- _____ Implantation of gold weight
- _____ Moderate sedation

I have requested only those privileges which I am qualified to perform by virtue of my education, training, current experience and/or demonstrated performance.

Applicant signature

Date

Approvals:

Department Chair

Date

Medical Board

Date

Hospital Board

Date