



Atrium Health

IMPORTANT

Dear Applicant

Enclosed you will find the Delineation of Privileges Form specific to your specialty. This form reflects the minimum qualifications as outlined and approved by the Atrium Health Medical Staff.

- Please thoroughly review and select your desired clinical privileges. Check the box corresponding to the privileges that you are requesting. Applicants should only request those privileges where the criteria has been achieved.
- After you have selected your privileges, sign, date, and submit the **required documentation** for each privilege selected. (i.e. case logs, fellowship director letter, ACLS documentation)
- Where case logs are required, please include 1) Date of procedure, 2) Medical Record Number, 3) Procedure Type and 4) Privilege Number listed on the Delineation of Privileges Form.
- Privileges for which you have not selected or do not meet the minimum criteria cannot be performed.
- If you wish to perform privileges and do not have documentation of the minimum criteria requirements as outlined on the Delineation of Privileges Form, you will need to request permission to proctor through Medical Staff Services.
- Failure to return the Delineation of Privileges Form along with the required documentation will **delay** your start date.

If you have any questions or concerns, please contact the Medical Staff Services teammate assigned to your file.

ATRIUM HEALTH DELINEATION OF PRIVILEGES SPECIALTY OF OPHTHALMOLOGY

	YES		NO**	I have participated in direct patient care within the past two (2) years.
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****If the answer is No, please do not complete this form. Contact the Medical Staff Office at (704) 355-2147 for additional instructions regarding the required proctoring process.**

- Initial appointment** **Reappointment** **Updated DOP** **Request for Clinical Privileges**

To be eligible for core privileges in Ophthalmology, the applicant must meet the following qualifications:

- If the applicant is not a Diplomate of the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology the applicant must provide:
1. Documentation of successful completion, within the past five (5) years, of an ACGME or AOA accredited residency training program in Ophthalmology; **AND**
 2. Documentation of the performance of at least seventy-five (75) ophthalmologic surgical procedures during the past two (2) years.
- If the applicant is currently a Diplomate of the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology the applicant must provide:
1. Provide documentation of specialty certification in Ophthalmology from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); **AND**
 2. Documentation of the performance of at least seventy-five (75) ophthalmologic surgical procedures during the past two (2) years.

Print Name _____

NOTE 1: “CORE” privileges cannot be amended or altered in any way.

NOTE 2: Please note that the exercise of certain privileges enumerated herein is necessarily limited by the operational, and resource constraints of the facility. All procedures must be performed within a clinical setting with the capabilities and organizational structure required to provide appropriate support.

Please check appropriate blocks when applying for privileges:

CMC	Pineville	University City	CR	Lincoln	Cabarrus	Union	Stanly	Anson	Cleveland		OPHTHALMOLOGY CORE PRIVILEGES
			N/A							COPH-1	Privileges to evaluate, diagnose, consult, and provide surgical and nonsurgical care to patients of all ages except as specifically excluded from practice and except for those special procedures listed below to correct or treat illnesses, injuries, and disorders of the eye, including its related structures and visual pathways.

Note: Privileges include but are not limited to, nasolacrimal duct obstruction probing and irrigation; enucleation/evisceration; exploration and repair of penetrating/perforating injury of the globe; cataract removal/implantation of intraocular lens (including secondary IOL) surgery; vitrectomy surgery by the anterior approach; laser iridotomy; panretinal photocoagulation; and YAG Capsulotomy.

CMC	Pineville	University City	CR	Lincoln	Cabarrus	Union	Stanly	Anson	Cleveland		CORE OPHTHALMOLOGY PRIVILEGES – REHABILITATION HOSPITAL SETTING <u>ONLY</u>
N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	COPH-2	Privileges include evaluation and management, as well as procedures approved for performance within the acute rehabilitation setting, in conjunction with the comprehensive rehabilitation treatment plan.

Print Name _____

*** SPECIAL PRIVILEGES WITH QUALIFICATIONS AND/OR SPECIFIC CRITERIA - PROVIDE THE NUMBER OF PROCEDURES PERFORMED WITHIN THE PAST TWO YEARS AND FACILITY WHERE THE PROCEDURES WERE PERFORMED.**

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLE	OPHTHALMOLOGY SPECIAL PRIVILEGES		Minimum Number Required	Number Performed Within The Past 2 Years	Location
										Must apply for and maintain Ophthalmology Core Privileges (COPH-1)				
			N/A							COPH-1(a)*	Cosmetic and/or Reconstructive Eyelid Surgery	10		
			N/A							COPH-1(b)*	Orbital Surgery	10		
			N/A							COPH-1(c)*	Pterygium Surgery	10		
			N/A							COPH-1(d)*	Strabismus Surgery	10		
			N/A							COPH-1(e)*	Glaucoma / Filtration Surgery	10		
			N/A							COPH-1(f)*	Minimally Invasive Glaucoma Surgery	10		
			N/A							COPH-1(g)*	Vitreoretinal / Retinal Reattachment / Vitrectomy Surgery by the Posterior Approach	10		
			N/A							COPH-1(h)*	Corneal Transplantation Surgery	10		
			N/A							COPH-1(i)*	Dacryocystorhinostomy and/or Laser Punctalplasty	10		
			N/A							COPH-1(j)*	Laser Trabeculoplasty and/or Laser Iridotomy	10		
			N/A							COPH-1(k)*	Laser repair of the retina, including but not limited to laser retinopexy for retinal tears, obliteration of choroidal neovascularization, and/or focal photocoagulation of the macula	10		

COPH-1(a) – COPH1-(k)

The applicant must meet the following:

1. Provide documentation of the successful completion of a residency program in Ophthalmology within the past two (2) years and have written documentation from the Program Director demonstrating competency in the requested privilege(s); **OR**
1. Provide a minimum number of ten (10) cases, for each privilege requested, performed for each request privilege(s) within the past two (2) years; **OR**
1. Submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges for each requested privilege(s). You must provide documentation of proctoring for ten (10) procedures for each requested privilege(s).

Maintenance Criteria for Continued Privileges:

The Physician must submit a minimum of five (5) procedures for each privilege held, over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for special privileges. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold any special privileges but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

REFERENCE

PRIVILEGES REQUESTED BY:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Atrium Health and;

I understand that:

- (a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

I attest that I am not currently a user of illegal drugs or do not currently abuse the use of legal drugs.

I attest that I do not have a physical or mental condition which could affect my motor skills or ability to exercise the clinical privileges requested or that I require an accommodation in order to exercise the privileges requested safely and competently.

Signature

Date

Print Name

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CASE LOG

Physician's Name: _____

Date: _____

	DATE	MEDICAL RECORD NUMBER	PROCEDURE TYPE	Name of procedure (as listed on DOP, e.g. COPH-1(a))
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			TOTAL	

