

**PACIFIC HOSPITAL OF LONG BEACH**  
**DELINEATION OF PRIVILEGES**  
**Department of Surgery/Anesthesia**  
*Ophthalmology Surgery*

Name of Applicant: \_\_\_\_\_

Board Certification: \_\_\_\_\_ Year of Certification: \_\_\_\_\_

Subspecialty: \_\_\_\_\_ Year of Certification: \_\_\_\_\_

<b>QUALIFICATIONS/CRITERIA</b>	
<b>Category I</b>	<b><i>Usual and Customary Privileges</i></b>
	<ol style="list-style-type: none"> <li>1. Complete an ACGME or AOA accredited residency in Ophthalmology Surgery.</li> <li>2. Board certification or qualification for certification by the American Board of Ophthalmology or AOA equivalent</li> <li>3. Demonstrated competence in Category I privileges.</li> </ol>
<b>Category II</b>	<b><i>Advanced Privileges - Procedures performed requiring special expertise and/or requiring documented special training and/or certification when it exists</i></b>
	<ol style="list-style-type: none"> <li>1. Board certification or in process of certification by the American Board of Ophthalmology;</li> <li>2. Requires documentation of ability to perform the procedure(s) as outlined below: <ul style="list-style-type: none"> <li>• Documentation of residency training and experience in the advanced procedure</li> <li style="text-align: center;"><b>OR</b></li> <li>• Additional fellowship training and certification by a training director with experience and demonstrated competence in the procedure requested.</li> </ul> </li> <li>3. Asterisked (*) procedures are high-risk, problem-prone which require specific training requirements.</li> </ol>

Name: \_\_\_\_\_

**Instructions: Please place a check mark in the REQUESTED column corresponding to the privileges requested.**

<b>Pacific Hospital of Long Beach</b>			
<i>Ophthalmology Surgery privilege form</i>			
<b>Requested</b>	<b>Usual and Customary Privileges</b>	<b>Granted</b>	<b>Special Conditions</b>
	<b>General</b>		
	Admitting		
	Consulting		
	History and Physical		
	<b>Category I</b>		
	<b>Conjunctiva</b>		
	Excision		
	Free Mucous Membrane		
	Graft		
	Repair		
	<b>Excision of Tumor</b>		
	Kronlein approach		
	Nafziger approach		
	<b>Eyeball</b>		
	Enucleation		
	Evisceration		
	Removal of I.O.F.B.		
	<b>Glaucoma</b>		
	Cyclodialysis		
	Cyrotherapy		
	Destructive Operation on Ciliary Body		
	Diathermy		
	Fistulizing Procedures		
	Iridectomy		
	Irodotomy (YAG)		
	Trabeculotomy, Trabecletomy		
	<b>Lens</b>		
	Aspiration		
	Capsulotomy (YAG)		
	Emulsification and suction		
	Excision (Cataract extraction)		
	Incision		
	Replacement with I.O. (prosthetic lens)		
	Suction		
	<b>Lids and Adnexa</b>		
	Excision		
	Graft		
	Repair		

Name: \_\_\_\_\_

**Pacific Hospital of Long Beach**  
*Ophthalmology Surgery privilege form*

<b>Requested</b>	<b>Usual and Customary Privileges</b>	<b>Granted</b>	<b>Special Conditions</b>
	Transplantation		
	<b>Naso Lacrimal Apparatus</b>		
	Dacryocystorhinostomy		
	Excision		
	Probing		
	Repair		
	<b>Orbit</b>		
	Exenteration		
	Exploration		
	Fracture repair		
	Orbitotomy		
	<b>Retina</b>		
	Argon laser		
	Cryo		
	Diathermy		
	Photocoagulation		
	Retinopexy		
	Scleral buckling		
	Scleral resection		
	<b>Sclera</b>		
	Excision		
	Graft		
	Repair		
	<b>Strabismus</b>		
	Advancement		
	Horizontal Rectus Surgery		
	Myotomy		
	Oblique Muscle Surgery		
	Recession		
	Recession		
	Transplantation of E.O.M.		
	Vertical Rectus Surgery		
	<b>Uveal Tract</b>		
	Excision (Iridectomy)		
	Incision		
	Repair		
	<b>Category II</b>		
	<b>Cornea</b>		
	Keratotomy		
	Keratoprosthesis		
	Lamellar Keratoplasty		

Name: \_\_\_\_\_

<b>Pacific Hospital of Long Beach</b> <i>Ophthalmology Surgery privilege form</i>			
<b><i>Requested</i></b>	<b><i>Usual and Customary Privileges</i></b>	<b><i>Granted</i></b>	<b><i>Special Conditions</i></b>
	Transplantation		
	<b>Vitreous</b>		
	Excision (Virectomy)		
	Incision- injection		
	Replacement (transplant)		

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**APPROVALS:**

Exceptions/limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Chief of Surgery/Anesthesia

\_\_\_\_\_  
Date

Credentials Committee approval on: \_\_\_\_\_

Medical Executive Committee approved on: \_\_\_\_\_

Board of Directors approved on: \_\_\_\_\_

Name: \_\_\_\_\_