

PRIVILEGES for the Advanced Practice Provider

Privileges in APP OPTOMETRY PRIVILEGES

Applicant's Name:

Instructions:

- 1. Click the **Request** checkbox to request a group of **Core** *Privileges*.
- $\begin{tabular}{ll} \bf 2. & {\bf Uncheck} \ \mbox{any privileges you do not want to request in this group.} \end{tabular}$
- ${\bf 3.} \quad \text{Individually check off any {\bf Special Privileges}} \ \ \text{you want to request.}$
- 4. Sign form electronically and submit with all required documentation.
- 5. To have **Administration of Sedation** privileges you must complete LPCH APP Sedation Privilege form (contact your medical staff coordinator for the form)
- 6. As the Supervising Physician I have reviewed and agree to the Supervision/Delegation of Services Agreement by signing this privilege form. The Supervision/Delegation of Services Agreement can be found here.

| Required Qualifications | | | |
|---------------------------------------|--|--|--|
| Education/Training | Successful completion of a professional optometric degree program leading to an OD. The program must be accredited by the Accreditation Council on Optometric Education (ACOE). AND | | |
| | Possession of a valid Therapeutic Pharmaceutical Agent (TPA) Certificate | | |
| Licensure (Initial and Reappointment) | Valid California state license to practice optometry | | |
| FPPE | FPPE CRITERIA LISTED BELOW. FPPE WILL BE ASSIGNED BY THE SERVICE CHIEF DURING THE APPROVAL PROCESS | | |

Core Privileges

Qualifications

Renewal Criteria

Minimum 100 cases required during the past 2 years

| Request | Request all privileges listed below. Uncheck any privileges that you do not want to request. | Supervising Physician Rec | Service Chief Rec |
|---------|---|---------------------------------|-------------------------|
| | Independently examine, diagnose, treat, and manage common ocular conditions, diseases, and injuries as specified by the state board of optometric practice. Appropriate consultation will be sought when needed. | | |
| | Core privileges in optometry include but are not limited to the following: | | |
| | Perform primary care examinations, including refraction | | |
| | Diagnose vision problems and eye diseases | | |
| | Test patients' visual acuity, depth and color perception, and ability to focus and coordinate their eyes | | |
| | Analyze test results and develop a treatment plan | | |
| | Provide pre- and postoperative care to cataract patients as well as those who have had laser vision correction or other eye surgery | | |
| | Provide emergency eye care services | | |
| | Diagnose conditions due to systemic diseases such as diabetes and high blood pressure, referring patients to other health practitioners as needed | | |
| | Administer topical ocular drugs for diagnostic and therapeutic purposes | | |

FPPE

Core - (Chart Reviews)
Core - (Direct Observations)

Acknowledgment of Applicant

I have requested only those privileges for which, by education, training and experience I am qualified to perform under the supervision of a physician, and that I wish to exercise at Lucile Packard Children's Hospital.

I attest that I have met all of the required criteria and will meet all competency requirements for each standardized protocol and/or standardized procedure that I have requested.

Also attest that I will adhere to the guidelines of the LPCH Job Description appropriate to my professional role as well as all standardized protocols and/or standardized procedures that I have requested.

| By clicking on the "Submit" button below, I have electronically signed, dated and submitted this | Date |
|--|------|
| privilege request | |

Service Chief Recommendation - Privileges

| rivilege | Condition/Modification/Deletion/Explanation | |
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| Service Chief Recommendation - FPPE Req | uirements | |
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| supervising Physician - By clicking on the 'Su igned, dated and approved this privilege req | | |
| Service Chief - By clicking on the 'Submit' but | on below, I have electronically signed, Date | |