UNMH Optometrist (OD) Clinical Privileges

Name:
Effective Dates: _____ To: _____

All new applicants must meet the following requirements as approved by the UNMH Board of Trustees effective: 12/19/2014

INSTRUCTIONS

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

OTHER REQUIREMENTS

1. Note that privileges granted may only be exercised at UNM Hospitals and clinics that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

2. This document defines qualifications to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

POLICIES GOVERNING SCOPE OF PRACTICE

Categories of Patients Practitioner May Treat

May provide services consistent with the policies stated herein to patients as part of a referral to the OD or from those referred by the medical staff member, or those with whom the OD has a documented formal affiliation.

Periodic Competence Assessment

Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the hospital system's existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide at this Hospital. In addition, continuing education related to the specialty area of practice is recommended.

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Qualifications for Optometry (OD)

Intial privileges *- To be eligible to apply for core privileges in optometry, the initial applicant must meet the following criteria:*

Satisfactory completion of a Doctor of Optometry (O.D.) degreed program at a college of optometry approved by the American Optometric Association's Council of Optometric Education (AOACOE).

AND

Current active certification and licensure to practice optometry issued by the New Mexico Board of Examiners in Optometry under the New Mexico Registration and Licensing Department.

AND

Required previous experience: Applicants must be able to demonstrate current clinical competence and that they have successfully provided inpatient, outpatient, or consultative optometry services in the privileges requested to at least 50 patients, in the past 12 months, or have completed an approved optometry training program in the past 12 months.

Reappointment requirements: *To be eligible to renew core privileges in optometry, the applicant must meet the following maintenance of privilege criteria:*

Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

CORE PRIVILEGES: *Optometrist*

Pediatric, adolescent and adult patients except as specifically excluded from practice.

☐ Requested

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Optometrist (OD) Core Procedures List

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, then initial and date.

1. Administer drugs for diagnostic and therapeutic purposes
2. Ambulatory co-management and follow-up care of pre and post-surgical patients; write patient treatment orders within the scope of practice according to licensure
3. Biomicroscopy
4. Comprehensive medical eye examination, diagnosis, and treatment on an inpatient or outpatient basis
5. Computerized Corneal Topography
6. Dilation and irrigation of lacrimal system
7. Direct and indirect ophthalmoscopy
8. Eyelash epilation
9. Foreign body removal (cornea, lid, conjunctiva)
10. General contact lens service; prescribe visual aids as necessary
11. Gonioscopy
12. Ophthalmic Diagnostic Imaging
13. Order relevant x-rays, lab tests, CT scans, MRIs, ultrasounds and electrodiagnostic procedures; i.e., VEP, EOG, ERG
14. Pachymetry
15. Photo documentation of the eye, adnexa, and related structures
16. Photography, anterior segment and retina
17. Punctal Occlusion by Plug
18. Refractive error evaluation
19. Retinoscopy
20. Scraping of Cornea, diagnostic for culture
21. Tonometry
22. Use of instruments and pharmaceutical agents to treat the eye, adnexa, and relates structures
23. Visual fields

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Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM Hospitals and clinics, 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 situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed _____ Date _____

Department recommendation(s)

I have reviewed the requested clinical privileges with the applicant and the supporting documentation for the above-named applicant and:

☐ Recommend all requested privileges with the standard professional practice plan
☐ Recommend privileges with the standard professional practice plan and the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege Condition/Modification/Explanation
Notes:

_____
_____
_____
_____

Division Chief Signature _____ Date _____

Print Name_____ Title _____

Department Chair Signature _____ Date _____

Print Name_____

Criteria approved by UNMH Board of Trustees on 12/19/2014