

## LIST OF CLINICAL PRIVILEGES – OPTOMETRY

**AUTHORITY:** Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.

**PRINCIPAL PURPOSE:** To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.

**ROUTINE USE:** Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.

**DISCLOSURE IS VOLUNTARY:** However, failure to provide information may result in the limitation or termination of clinical privileges

### INSTRUCTIONS

**APPLICANT:** In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Clinical Supervisor

**CLINICAL SUPERVISOR:** In Part I, using the facility master privileges list, enter Code 1, 2, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form and forward the form to the Credentials Office.

**CODES:** 1. Fully competent within defined scope of practice.

2. Supervision required. (Unlicensed/uncertified or lacks current relevant clinical experience.

3. Not approved due to lack of facility support. (Reference facility master Strawman. Use of this code is reserved for the Credentials Function.)

4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.

**CHANGES:** Any change to a verified/approved privileges list must be made in accordance with Service specific credentialing and privileging policy.

**NAME OF APPLICANT**

**NAME OF MEDICAL FACILITY**

I Scope		Requested	Verified
<b>P383291</b>	The scope of privileges in optometry includes the evaluation, diagnosis, treatment, and consultation for disorders, diseases, and injuries of the eye, associated structures and the visual system through a variety of tests and measurements. They identify systemic conditions affecting the eyes and vision and refer patients to other providers as indicated. Optometrists provide pre and post-operative assessments. Optometrists use topical diagnostic and therapeutic medications, fit and prescribe eyeglasses and contact lenses, and co-manage conditions that affect the ocular health and vision of their patients.		
Diagnosis and Management (D&M)		Requested	Verified
<b>P383296</b>	Developmental and perceptual vision screening		
<b>P383298</b>	Interpretation of fluorescein angiography		
<b>P383300</b>	Traumatic Brain Injury (TBI) vision/neurosensory visual evaluation and management		
<b>P383302</b>	Low vision evaluation and prescription of low-vision devices		
<b>P385998</b>	Prescribe medications in accordance with Military Treatment Facility (MTF) Pharmacy and Therapeutics (P&T) policy		
Procedures		Requested	Verified
<b>P383304</b>	Specialty contact lens fitting including scleral lenses		
<b>P383306</b>	Dilation, probing and irrigation of lacrimal punctum, canaliculi, and sac		
<b>P383308</b>	Ophthalmodynamometry		
<b>P419152</b>	Multiple punctures of anterior cornea		
<b>P419153</b>	Correction of trichiasis (epilation by forceps only)		
Procedure Advanced Privileges: (Requires Additional Training):		Requested	Verified
<b>P383310</b>	Chalazion incision and drainage		
<b>P383312</b>	Intralesional steroid injection of chalazion		
<b>P383314</b>	Retinal electrophysiologic studies		
<b>P383318</b>	Periocular skin excision/biopsy		
<b>P388689</b>	Visual evoked potentials testing and interpretation		
Other (Facility- or provider-specific privileges only)		Requested	Verified
<b>SIGNATURE OF APPLICANT</b>		<b>DATE</b>	

**CLINICAL PRIVILEGES – OPTOMETRY (CONTINUED)**

**II CLINICAL SUPERVISOR'S RECOMMENDATION**

**RECOMMEND APPROVAL**

**RECOMMEND APPROVAL WITH MODIFICATION**  
(Specify below)

**RECOMMEND DISAPPROVAL**  
(Specify below)

**STATEMENT:**

**CLINICAL SUPERVISOR SIGNATURE**

**CLINICAL SUPERVISOR PRINTED NAME OR STAMP**

**DATE**