

**THE NEW YORK EYE AND EAR INFIRMARY**

**DELINEATION OF PRIVILEGES**

**DEPARTMENT OF OPHTHALMOLOGY**

**AMBULATORY/INPATIENT**

**NAME:**

(PLEASE PRINT)

**Instruction:**

**Applicant: Please put a tick( ✓) in the Privilege Requested Column**

**Procedures requiring additional training or fellowships are marked accordingly.**

**Chairman/Director: Please put tick ( ✓) in the appropriate column.**

		<b><u>DIRECTOR OF SERVICE</u></b>	
	Privilege Requested	Privilege Denied	Privilege Approved
<b>Category I.</b> <b>Medical Management</b> and diagnostic tests for the eye, orbit, visual system and adnexae.		_____	_____
<b>Category II</b> Ocular Surgery including related diagnostic and treatment procedures.		_____	_____
Operations on Lacrimal Apparatus		_____	_____
Dacryocystostomy		_____	_____
Dacryocystorhinostomy		_____	_____
Operations on <b>EYELIDS</b>		_____	_____
Operations on <b>CONJUNCTIVA</b>		_____	_____
Operations on <b>ORBIT</b> and <b>OPTIC NERVE SHEATH</b>		_____	_____
- Orbitotomy ( <b>Fellowship training required</b> )		_____	_____
Operations on <b>EYEBALL</b> and <b>MUSCLES</b>		_____	_____

	<b><u>DIRECTOR OF SERVICE</u></b>		
	Privilege Requested	Privilege Denied	Privilege Approved
Operations on <b>CORNEA</b> and <b>SCLERA</b>		_____	_____
INTACS (Intrastromal Ring) ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Keratoplasty		_____	_____
Radial and astigmatic keratotomy ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Excimer Laser/VISX ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Autonomous Laser ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Automated Lamellar Keratoplasty/LASIK ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Keratoprosthesis ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Artificial Cornea ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Glaucoma Canaloplasty and Trabectome ( <b>Proof of appropriate instruction course required</b> )		_____	_____
Congenital and Pediatric ( <b>Fellowship training required</b> )		_____	_____
Setons		_____	_____
Operations on <b>IRIS</b> and <b>CILIARY BODY</b>		_____	_____
Selective Laser Trabeculoplasty (SLT)		_____	_____
OPERATIONS on <b>CHOROID, RETINA</b> and <b>VITREOUS</b>		_____	_____

	<b><u>DIRECTOR OF SERVICE</u></b>		
	Privilege Requested	Privilege Denied	Privilege Approved
Photodynamic Therapy (PDT) with Verteporfin (Visudyne) (Proof of appropriate instruction course required)		_____	_____
OPERATIONS on <b>LENS</b> and <b>VITREOUS</b> , ANTERIOR CHAMBER		_____	_____
<b>ENUCLEATION</b> with implant		_____	_____
Dermis fat graft		_____	_____
<b>Evisceration</b> with implant		_____	_____
Exenteration		_____	_____
<b>Grafting Procedures</b> full thickness skin grafts		_____	_____
Split thickness grafts ( Fellowship training required)		_____	_____
Hard palate grafts ( Fellowship training required)		_____	_____
Multi-Focal and Accommodative IOL (Proof of appropriate instruction course required)		_____	_____
<b>Implantation</b> of intraocular lens		_____	_____
Cataracts Congenital		_____	_____
Extraction <b>without</b> IOL under 18 Years of Age		_____	_____
Extraction <b>with</b> IOL under 18 Years of Age		_____	_____
<b>THERMAL LASER PHOTOCOAGULATION</b> (Argon, Krypton, Diode)		_____	_____
<b>YAG LASER PHOTODISRUPTION</b>		_____	_____

**DIRECTOR OF SERVICE**

Privilege  
Requested

Privilege  
Denied

Privilege  
Approved

**CO<sub>2</sub> LASER** for Aesthetic Applications  
(Proof of appropriate instruction course required)

\_\_\_\_\_

\_\_\_\_\_

**ERBIUM YAG LASER**  
(Proof of appropriate instruction course required)

\_\_\_\_\_

\_\_\_\_\_

**CANDELA LASER**  
(Proof of appropriate instruction course required)

\_\_\_\_\_

\_\_\_\_\_

Endoscopic Cyclophotocoagulation  
(Proof of appropriate instruction course required)

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**APPROVED:** \_\_\_\_\_  
**Joseph B. Walsh, M.D., FACS**  
**Chairman, Ophthalmology**

**DATE:** \_\_\_\_\_  
Revised 12.20.2007