Department of Ophthalmology
Optometry and Orthoptics - Privilege Request Form

Basic Education/Certificates:

Optometry: O.D. degree or foreign equivalent; Current License issued by the State Board of Optometry to practice Optometry.
Orthoptics: Bachelor's degree or equivalent degree followed by formal graduate training in orthoptics; Certification administered by the American Orthoptic Council or equivalent body.

Minimum Formal Training:

Optometry**:** Requiring a level of training generally associated with persons who have completed a formal graduate program in Optometry.
Orthoptics: Requiring a level of training generally associated with persons who have completed a formal graduate program in Orthoptics.

Courtesy Providers: Courtesy providers who do not meet the activity levels for maintenance/renewal criteria for particular privileges may submit – from their primary practice location—either;

A.) A peer reference from the service Chief or Chair attesting to clinical competence in the requested privileges, or
B.) Case-logs of clinical activity from their primary practice location.

I am requesting the specific privileges marked below. I understand that I may request additional privileges, or privileges in another Clinical Department, at any time. I also understand that the granting of these privileges is subject to verification of proficiency by the Chair of the Department, the Credentials Committee of the Medical Staff, and/or any other person or body appropriately designated under the Bylaws, Rules and Regulations of the Medical Staff.

I understand that in an emergency (any situation in which any delay in administering treatment would result in serious harm to the patient or an immediate threat to the life of the patient), I am authorized to treat any medical disease and/or perform any medical or surgical procedure indicated that is within the scope of my license.

Applicant Name: _____

Category 1 Optometrist and Orthoptist Privileges

Requests	Privilege Description	Initial Criteria	Renewal Criteria
☐	**A – Optometrist** Obtain ophthalmic history. ● Performs ocular examination and performs or directs associated testing for the purpose of diagnosis of visual disorders and disorders of ocular health and treats these conditions within the scope of their professional license and according to the regulations outlined in California State Board of Optometry Laws and Regulations. ● Application of eyedrops for both diagnosis and treatment as outlined in California State Therapeutic Pharmaceutical Agent certification. ● Contact lens fittings. ● Low vision evaluation and treatment. ● Refer patients for unexplained visual loss, ophthalmic disease not improving on medical therapy during the designated time frame, and/or ophthalmic disease needing surgical intervention.	**Criteria:** See **Minimum Formal Training** above.	**Optometrist Criteria:** Met the requirements for the renewal of the California optometry license with Therapeutic Pharmaceutical Agent certification. Maintains a minimum patient volume of optometric examinations of 15 patients per week.
☐	**B – Orthoptist** Performs ocular examination and associated testing for the purpose of diagnosis of visual disorders and disorders of ocular health. Designs and/or monitors a program of non-surgical treatments of strabismus, amblyopia, and disorders of binocular vision including: pre- and post-operative sensorimotor evaluations; management of diplopia including but not limited to the fitting of ophthalmic prisms or filters; designs eye exercises to improve binocular function, recommendation, implementation and/or modification of amblyopia therapy; and recommends modification of refractive correction.	**Criteria:** See **Minimum Formal Training** above.	**Orthoptist Criteria:** Maintains a minimum patient volume of orthoptic examinations of 15 patients per week.

APPLICANT'S SIGNATURE: _____

Date: _____

DEPARTMENTAL REVIEW AND RECOMMENDATION

I am not aware of any physical or mental health status issue that could in any way impair this individual's abilities to practice within the privileges requested.

_____ _____

UCSF Division Chief Signature: **NAME, MD** Date

_____ _____

UCSF Department Chair Signature: **NAME, MD** Date