DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date:

OPTOMETRIC PRIVILEGES REQUEST FORM

INTRODUCTION

The Optometrist clinical privilege application must be accompanied, or preceded, by a completed application for medical staff appointment, including the necessary supporting documents. The most common privileges practiced by optometrists will be found in this document, but many may still have to be added by the applicant. This can be done by "writing in" additional privileges on the bottom of the page.

INSTRUCTIONS FOR COMPLETING THE FORM

Applicant: With a check mark in the appropriate location, indicate for each item if privileges are requested. Be sure to sign the request as indicated on page 4.

Discipline-specific supervisor or area optometry consultant: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location. This recommendation is considered by the privilege granting authority. Be sure to sign the request as indicated on page 4. Recommended limitations or denial of privileges must be explained in detail on an attached sheet.

Note: Any patient admitted to an IHS hospital for ocular procedures must have an admission history and physical exam conducted by a physician member of that hospital's medical staff. Any non-ocular medical problem(s) present on admission, and any which occur during the hospital stay, must be evaluated and managed by a physician member of that hospital's medical staff.

CREDENTIALS AS EVIDENCE OF COMPETENCY

I. CLASS I OPTOMETRIC PRIVILEGES

A. Education

A degree of doctor of optometry is required from one of the schools or colleges of optometry listed as accredited by the Council on Optometric Education of the American Optometric Association (COEAOA).

B. Licensure

A full and unrestricted license is required to practice optometry in a State, a Territory, or the District of Columbia, if hired as a civil servant. A commissioned officer of the U.S. Public Health Service (USPHS) must meet the USPHS optometry appointment standards.

II. CLASS II OPTOMETRIC PRIVILEGES

An optometrist is eligible for additional clinical privileges, if the following credentials are provided:

a. A license to practice optometry and a State certification to use therapeutic pharmaceutical agents.
b. If (a) is not satisfied, evidence of one or more of the following is required:

1. Training or experience such that the optometrist now holds IHS privileges or equivalent, consistent with appropriate portions of Class II privileges, and these privileges *have been held* and regularly reviewed over the *prior two* or more years.
2. Successful completion of at least 1 year of postgraduate training in a fellowship or primary care residency program accredited by the COEAOA.
3. Diplomate of the American Academy of Optometry in ocular disease in primary care.
4. Successful completion of a minimum 106-hour course in the management of ocular diseases and/or conditions as certified by an accredited optometric educational institution.
5. A passing score on a national certifying examination in the treatment and management of ocular diseases and/or conditions.

OPTOMETRY PRIVILEGES REQUEST FORM

I. CLASS I OPTOMETRIC PRIVILEGES

	Applicant Requests		Supervisor/ Consultant Recommends*		
	Ltd.	Full	N.R.	Ltd.	Full
A. General optometric examination, diagnosis and optical therapy	☐	☐	☐	☐	☐
B. Medical laboratory studies	☐	☐	☐	☐	☐
C. Ocular imaging studies	☐	☐	☐	☐	☐
D. Photo documentation	☐	☐	☐	☐	☐
E. Diagnostic pharmaceutical agents	☐	☐	☐	☐	☐
F. Extended posterior segment evaluation	☐	☐	☐	☐	☐
G. Visual fields testing/evaluation	☐	☐	☐	☐	☐
H. Low-vision management	☐	☐	☐	☐	☐
I. Contact lens management	☐	☐	☐	☐	☐
J. Oculomotor/perceptual/papillary problems	☐	☐	☐	☐	☐
K. Non-invasive management of lid conditions	☐	☐	☐	☐	☐
L. Non-invasive care of external eye injuries/burns	☐	☐	☐	☐	☐
M. Epilation of lashes	☐	☐	☐	☐	☐
N. Conjunctivitis therapy with topical medications	☐	☐	☐	☐	☐
O. Lacrimal function evaluation (non-invasive)	☐	☐	☐	☐	☐
P. Corneal abrasion care	☐	☐	☐	☐	☐
Q. Nonperforating foreign substance removal	☐	☐	☐	☐	☐
R. Management of keratitis-sicca and other epithelial keratitis (non microbial)	☐	☐	☐	☐	☐
S. Gonioscopy	☐	☐	☐	☐	☐
T. OTC oral medications for ocular disease	☐	☐	☐	☐	☐
U. Emergency treatment of life/sight threatening condition prior to referral	☐	☐	☐	☐	☐
V. Other (specify): ______________________________	☐	☐	☐	☐	☐

*This person is always an optometrist.

II. CLASS II OPTOMETRIC PRIVILEGES

The necessary pharmaceutical agents are approved to complete the indicated diagnostic/non-invasive therapeutic procedures for the following:

	Applicant Requests		Supervisor/ Consultant Recommends*		
	Ltd.	Full	N.R.	Ltd.	Full
A. Ultrasound measurement/evaluation	☐	☐	☐	☐	☐
B. Punctum dilation/plugs/irrigation	☐	☐	☐	☐	☐
C. Anterior uveitis care	☐	☐	☐	☐	☐
D. Medical hyphema management	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

	Applicant Requests		Supervisor/ Consultant Recommends*		
	Ltd.	Full	N.R.	Ltd.	Full
E. Open angle glaucoma					
F. Acute glaucoma					
G. Lids and periorbital skin conditions					
H. Keratitis					
I. Episcleritis					
J. Post-surgical eye care					
K. Other (specify): ______________________________					

*This person is always an optometrist.

OPTOMETRY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

______________________________ ______________
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

______________________________ ______________
Service Unit O.D. or Date
Area Optometry Consultant

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (check one)

____ As noted.

____ With the following exceptions, deletions, additions, or conditions:

____

______________________________ ______________
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

______________________________ ______________
Service Unit Director Date

5. Privileges are hereby granted: (check one)

____ As noted.

____ With the following exceptions, deletions, additions, or conditions:

____

______________________________ ______________
Chairperson of the Date
Governing Body

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.