NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

OPHTHALMOLOGY

Ophthalmological Procedures:

PRIVILEGE CRITERIA

1. Attestation (**Attachment 1 - in attestation format provided**)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of ophthalmological procedures which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (**Attachments 2A and, depending upon privileges requested, Attachments 2B and 2C**)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in ophthalmology granted by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology and Otorhinolaryngology or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an ACGME/AOA accredited residency training program in ophthalmology, **OR**

(3) Supervised training in residency or fellowship or other equivalent experience in _____ **(another field**) **AND** active participation in examination process leading to certification in ophthalmology.

Use of Laser (**Attachment 2B):**

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, **OR**

(2) Documentation from the program director of an accredited resident training program attesting to the training in specific laser therapy during residency training.

Procedures Requiring Additional Training (Attachment 2C)

I have attached, as Attachment(s) 2C documentary evidence of the required additional training for each of the following procedures, if privileges are requested for these procedures:
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- Glaucoma surgery
- retinal surgery (including for retinal detachment)
- lacrimal sac surgery

additional training: Completion of a specific fellowship in the **requested** procedure(s)

OR

additional training: Documentation from the program director of an accredited residency training program attesting to the training during residency in the **requested** procedure(s)

PLUS

Documentation (**additional reference Attachment 3A**) from a privileged physician who has directly observed the applicant's successful performance or participation in the **requested** procedure(s).

3. Record Review/Clinical Observation (Attachment 3 and, depending upon privilege requested, Attachment 3A - in format provided):

References - Names, addresses and specialty, residency or observation only

I am providing the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

A. Reference for Requested Procedure(s) requiring additional training

I am providing the name, address and specialty of a privileged physician who has directly observed my successful performance or participation in the **requested** procedure(s). and whom I have asked to directly submit a reference addressing my current competence based on their personal knowledge obtained through personal observation of my successful performance or participation in the requested procedure.

4. Log of procedures (**Attachment 4A, for each privilege requested - in format provided**)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. Each log includes a patient number, the type of anesthesia

service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges, will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each.

_____

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

_____ Radial Keratotomy
_____ Astigmatic Keratotomy
_____ Automated Lamellar Keratoplasty - SEE ALSO LASER.
_____ Blepheroplasty - SEE ALSO LASER.
_____ Retrobulbar block
_____ Repair of lacerations
_____ Removal/excision of lid tumors
_____ Lacrimal sac surgery - **requires additional training** -SEE ALSO

LASER.
_____ Cataract surgery - SEE ALSO LASER.
_____ Intraocular lens implantation
_____ Glaucoma surgery - **requires additional training** - SEE ALSO LASER.

Corneal lacerations

_____ Corneal foreign bodies
_____ Pterygium excision
_____ Retinal surgery - **requires additional training** - SEE ALSO LASER.
_____ Keratoplasty

_____ Corneal or refractive surgery - please specify technique - SEE ALSO LASER.
_____ Anterio chamber paracentesis
_____ Photorefractive Keratectomy (PRK) without laser.
_____ Phototherapeutic Keratectomy (PTK) without laser.
_____ Other - Please specify and provide supporting documentation on a separate page: ____

Use of Laser:

Each requires additional training in specific laser use.
_____ Automated lamellar keratoplasty: Excimer
_____ Lacrimal sac surgery: CO2, NdYAG, Argon
_____ Cataract surgery: NdYAG
_____ Glaucoma surgery: Argon, NdYAG, Diode
_____ Retinal surgery: Argon, Diode
_____ Photorefractive Keratectomy (PRK) Excimer
_____ Phototherapeutic Keratectomy (PTK) Light
_____ LASIK Excimer
_____ Blepharoplasty: CO2 and Erbium

Please specify procedure(s) and laser (for each) and provide supporting documentation on a separate page: _____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me and/or if the materials submitted by me are willfully false, I am subject to punishment.

_____
Signature of Applicant Date

Application Tracking Record:
Initial Receipt Date of Application
Transmittal Date to Outsourcing Entity
Supplemental Information Requested
Supplemental Information Received
Outsourcing Entity Recommendation
Outsourcing Entity Reviewer
Board Committee Review Date
Board Disposition Date