

**TEXAS SPINE & JOINT OUTPATIENT SURGERY CENTER  
 DELINEATION OF PRIVILEGES  
 Pediatric Ophthalmology and Adult Strabismus**

NAME: \_\_\_\_\_

INITIAL APPOINTMENT/REAPPOINTMENT  
 (CIRCLE ONE)

REQUESTED	PRIVILEGE	APPROVED	DENIED
	Inclu Cyst		
	Exc. Benign Lesion		
	Exc. Lesion of skin		
	Repair of Lid Laceration		
	Removal of Suture		
	Interanasal FB		
	Fracture Nasal Turbinates		
	Oculinum Injection		
	FB Rem W/WO SL		
	Scleral Lac Correction		
	Synechiae Posterior		
	Strabismus 1 Muscle		
	Strabismus 2 Muscle		
	Strabismus SX		
	Strabismus, 2 Vertical		
	Strabismus, Superior		
	Transposition Procedure		
	Strabismus SX Procedure		
	Any Muscle procedure		
	Strabismus SX W/WO Muscle Recession		
	Strabismus Surgery		
	Release of Scar Tissue		
	Chemodenervation		
	Orbitotomy w/ Biopsy		
	Optic Nerve Sheath Fenestration		
	Chalazion EX SG		
	Chal, I & D General		
	Trich Corr Forceps		
	Excision of Lesion		
	Frontalis Muscle Sling		
	Blep internal		
	Tarso Levator Repair		
	Entropion Repair		
	Suture of Wound		
	Biopsy Conjunctiva		
	FB Lacrimal Puncta		
	Canaliculi Repair		
	Lacri Duct Probe		
	Lacrimal Duct Probe		
	Balloon Catherer		
	Exam Gen. Anes		

**Acknowledgement of Practitioner**

**I am qualified to perform the privileges I have requested based on my licensure, education, training, experience and current competence. I certify that I am able to perform the privileges I have requested.**

\_\_\_\_\_  
**Practitioner's Signature**

\_\_\_\_\_  
**Date**