Privileges for: Ophthalmic Assistant

Request

ST. ELIZABETH - EDGEWOOD
ST. ELIZABETH - FLORENCE
ST. ELIZABETH - FT. THOMAS
ST. ELIZABETH - GRANT CO. (Surgical & other invasive procedures requiring general anesthetic are not offered)

SCOPE OF PRACTICE FOR OPHTHALMIC ASSISTANTS

MINIMUM REQUIREMENTS:
Ophthalmic Assistants are required to be certified in one of the following areas of certification:
C.O.A. (certified Ophthalmic Assistant)
C.O.T. (Certified Ophthalmic Technician)
C.O.M.T. (Certified Ophthalmic Medical Technologist)

OR

Licensed as a registered nurse or licensed practical nurse in the State of Kentucky

The allied health professional will remain under the direct in-person supervision of the employer physician. The AHP will be involved in the care of patients of only the employer physician.

DEPARTMENT APPROVAL

_____Approved _____Disapproved

_____ _____
Department/Section Chair Signature **Date**

Nursing Administration Approval

_____ _____
Sr. V.P. of Nursing or Designee Signature

_____ Assists employer ophthalmologist with organizing charts, intraocular lens order, readies forms for the chart that require signature, assists in keeping track of patient order on the surgery schedule (when changes are necessary); rechecks intraocular lens power on each patient having surgery and makes sure there are two lenses picked for each patient; communicates to families that employer physician will speak with them at their post-op visit the next day; organizes and provides post-op eye care kits and gives eye drops as directed by employer ophthalmologist in his/her presence.

I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.

Last 4 digits of S.S.N._____

SUPERVISING PHYSICIAN ENDORSEMENT: As the applicant's supervising physician, I have read the foregoing application for Scope of Practice and have indicated by my initials and date above the appropriate levels of supervision I will employ to promote the safety and care of our patients at a generally recognized professional level of quality and efficiency. I acknowledge my continuing responsibility for supervising this applicant until such time as he or she secures another supervising physician.

_____ _____
Sponsoring Physician's Signature **Date**

I agree that the use of my electronic signature below indicates my intent to sign this document as if it were my original handwritten signature.

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Applicants Signature: _____ **Date:** _____