UNIVERSITY OF MARYLAND MEDICAL CENTER MIDTOWN CAMPUS
Optometry
Delineation of Privilege Form

Name:_____ **Date:** _____

Privilege / Operative Procedure	Applicant Check (√) if requested	Department Chief (Initial)		
		Recommended	Not Recommended	Conditions (provide explanation)
Category I Privileges				
Perform eye examinations				
Prescribe corrective lens, including contacts				

Acknowledgment of Practitioner:

I have requested only those specific privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform and for which I wish to exercise at UMMC Midtown Campus. I understand that in exercising any clinical privileges granted, I am constrained by all UMMC Midtown Campus medical staff policies and rules applicable generally and all applicable to the particular situation.

_____ _____

Applicant's Signature **Date**