



ALLIED HEALTH SPECIALTY SHEET

Optometry

Please list any limitations or comments you may have on a separate sheet.

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname	
				Date of Birth	
CERTIFICATIONS	<input type="checkbox"/> BLS expires: _____				
POPULATIONS WORKED WITH	<input type="checkbox"/> Adults <input type="checkbox"/> Pediatrics				
PRACTICE SETTINGS	<input type="checkbox"/> Medical Group Practice <input type="checkbox"/> Primary Care w/Refraction <input type="checkbox"/> Retail or free-standing vision center based primary care				
SCOPE OF PRACTICE	<i>Please check your clinical capabilities, and where indicated, list the approximate number of procedures performed within the past 24 months</i>				
	<i>Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.</i> <i>You may not be considered for approval in clinical areas where a box is not checked, or where indicated, a number is not provided.</i>	Visual Assessment*		Eye Conditions/Diseases* (Including but not limited to the following)	
		<input type="checkbox"/> Eye examination		<input type="checkbox"/> Anterior segment	
		<input type="checkbox"/> Pathology		<input type="checkbox"/> Acanthamoeba	
		<input type="checkbox"/> Refraction		<input type="checkbox"/> Conjunctivitis	
		<input type="checkbox"/> Color Deficiency (non-genetic or genetic)		<input type="checkbox"/> Keratoconus	
		<input type="checkbox"/> Eye coordination		<input type="checkbox"/> Posterior segment	
				<input type="checkbox"/> Diabetic retinopathy	
		Prescriptive practice		<input type="checkbox"/> Cataracts	
		<input type="checkbox"/> Eyeglasses		<input type="checkbox"/> Glaucoma	
		<input type="checkbox"/> Contacts		<input type="checkbox"/> Retinal tear	
		Medications- <input type="checkbox"/> Topical		<input type="checkbox"/> Retinal detachment	
		<input type="checkbox"/> Systemic		<input type="checkbox"/> Vitreous detachment	
				<input type="checkbox"/> Adnexa	
		Other Procedures		<input type="checkbox"/> Blepharitis	
<input type="checkbox"/> Foreign body removal #		<input type="checkbox"/> Chalazion			
<input type="checkbox"/> Vision therapy		<input type="checkbox"/> Retinoblastoma			
<input type="checkbox"/> Visual rehabilitation		Post-Op Management			
		<input type="checkbox"/> 1 st Day #			
		<input type="checkbox"/> Cataract			
		<input type="checkbox"/> LASIK			

***DEFINITIONS - Visual Assessment** – Obtaining history and performance of visual exam to determine course of treatment.
Eye Conditions/Diseases - Differential diagnosis of various ocular pathologies; diagnosis and initial treatment, ongoing assessment and referral to a specialist with co-management when indicated.

Please check the type of work-related equipment you have used: Slit-lamp (Bio-microscope) Slit-lamp w/indirect lens BIO (Binocular Indirect Ophthalmoscope)
 Automated-Perimetry 3-D Fundus Photography Nerve Fiber Analyzer

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____