



Specialty Surgery Center
322 22nd Avenue North | Nashville, TN 37203
(615) 321-6161 | fax (615) 645-9870 | www.ssctn.com

Re-Credentialing Application: Surgical Assistant / Technician

Dear Applicant,

Thank you for your continued interest in providing services at our facility. The following application is required by state regulations and facility bylaws for you to continue performing functions as an Ophthalmologic Instrument Technician as defined below:

An Ophthalmologic Instrument Technician must:

1. Currently be employed by a licensed, practicing physician in the state of Tennessee
2. Have previously completed the Sterile Technique Seminar provided by Specialty Surgery Center
3. Proof of proficiency in appropriate use of Aura and LensX ophthalmologic systems (if applicable)

In addition to this application, you will need to submit the following documentation before your application is considered complete:

- _____ Copy of current Tennessee issued Surgical Technician License (if applicable)
- _____ Copy of recent tuberculosis skin test results (PPD)
- _____ Copy of current BLS/CPR certification,
- _____ \$50 application fee

The credentialing process will begin upon receipt of your complete Re-Credentialing Application as well as the initial application fee of \$50. This application should be submitted prior to expiration of your previously granted privileges. Once this application has been processed, privileges are again active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact me via email at cdavenport@ssctn.com or phone at (615) 321-6161 ext 1001. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center

**Re-Credentialing Application:
Ophthalmologic Instrument Technician**

Section I: Demographic Information

Last Name	First Name	Middle Initial	Gender
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_____-_____-_____
Social Security Number

_____/_____/_____
Date of Birth

Preferred Contact Method: E-mail Phone Fax

Primary Practice Name

Office Manager/Contact

Primary Practice Address

City

State

Zip

(_____) _____ - _____
Practice Telephone

(_____) _____ - _____
Practice Fax

E-mail Address

Emergency Contact Person

(_____) _____ - _____
Emergency Contact Phone

Emergency Contact Relation To You

Section II: Professional License/Certification Information
(Attach copies of all licenses and certifications)

License Number: _____ Date Issued: ____/____/____ Expiration: ____/____/____

Date of Sterile Technique Course administered by Specialty Surgery Center: ____/____/____

**Please specify if you hold any of the following certifications and attach proof of certification(s):*

_____ Proof of proficiency in using LensX ophthalmologic system

_____ Proof of proficiency in using Aura ophthalmologic system

BLS (CPR) Certification Expiration Date: ____/____/____

Section III: Supervising Physician Information

Name of Physician currently on staff at Specialty Surgery Center who will be supervising you:

Physician Name (please print)

Physician Signature

Date

Section IV: Conditions of Application

I attest that the information contained in this profile and all enclosed/attached documents, which are agree to provide to support this profile, are complete and accurate. I agree to notify SSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

Printed name of Ophthalmologic Technician Applicant

Date

Signature of Ophthalmologic Technician Applicant



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Authorization for Ophthalmologic Technician

(To be filled out by sponsoring physician)

This is to certify that I, _____, a duly licensed Doctor of Medicine admitted to practice the art of medicine in the State of Tennessee do hereby apply for permission from the Credentialing/Medical Director to allow me to employ an assistant while practicing medicine at the Specialty Surgery Center.

I further certify and declare that I am admitted with full staff privileges to the Medical Staff of this facility.

I further certify and declare that the Assistant, whose name is _____ shall at all times be my employee and shall never, for any reason, be considered to be an employee, agent or servant of the facility. I also declare that I shall, at all times, be personally responsible for any and all acts of aforementioned assistant while he/she is on the premises of the Specialty Surgery Center.

I further certify that the assistant is qualified and he/she will provide the Director of Nursing of Specialty Surgery Center acceptable proof of licensure, certification, or training.

I certify to all parties that I will always have direct supervision over and that I will be physically present to monitor his/her actions when necessary.

I further agree that I shall indemnify and hold the center and the partnership harmless from any and all claims relating to my assistant under the agreement and shall pay all expenses, including attorney's fees relating to any such claims.

A photocopy of this shall serve as the original.

Full Name of Sponsoring Ophthalmologist (Printed)

Signature of Ophthalmologist

Date



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Release of Information

By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Director of Nursing, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts.

A photocopy of this shall serve as the original.

Full Name (Printed)

Signature

Date



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Total Release of Liability

I, _____, an Allied Health Professional of the Specialty Surgery Center (SSC), understand that SSC's first priority is to meet the needs of the patient. In meeting this goal, I understand that Specialty Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Specialty Surgery Center from any liability during my stay as an Allied Health Professional at Specialty Surgery Center.

Full Name (Printed)

Signature

Date

Witness Signature

Date



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**Full Approval of Re-Appointment for:
Ophthalmologic Instrument Technician**

(This Page Official Use Only)

Full Name (Printed)

Re-Appointment Begins

Re-Appointment Expires

Approved By Credentialing Staff:

Compliance Officer Signature

Date

Approved By Governing Body:

President, Specialty Surgery Center

Date