



DIAGNOSTIC TELERADIOLOGY
Delineation of Privileges

Qualifications: Current board certification by the American Board of Radiology or the American Osteopathic Board of Radiology, or its equivalent, properly licensed in the State of Louisiana and credentialed by NightHawk Radiology Services, LLC, currently working under contract agreement with Teche Regional Medical Center.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No		(R)	(A)	(N)	(C) Condition/Reason(s)
		<p>Core privileges in Diagnostic Teleradiology includes the reading and interpretation of any diagnostic imaging study that can be sent over a telemedicine link, including but not limited to the following:</p> <ul style="list-style-type: none"> • Computed Tomography (CT) Scans • Ultrasound • Magnetic Resonance (MR) Scans • Nuclear Medicine • Plain Films <p>[All Teleradiologists are expected to adhere to current ACR Practice Guidelines for Communication of Diagnostic Imaging Findings]</p>				

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center.

Signature of Applicant

Date

Printed Name

Requested privileges reviewed and recommended as indicated above.

Signature of Service or Department Chair

Date

Board of Trustees' Decision

Teche Regional Medical Center's Board of Trustees

Does

Does not grant clinical privileges as requested

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

Secretary, Board of Trustees

Date



HEALTH STATEMENT

TO CHIEF OF SERVICE / CHIEF OF STAFF

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, ADDICTION, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, WHICH COULD OR IS LIKELY TO AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR WHICH MAY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES NO

If yes, please explain:

3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST? YES NO

If yes, please give date of positive skin test. _____

If no, when was your last PPD test? _____

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

SIGNATURE OF APPLICANT

DATE

CHIEF OF SERVICE

DATE