



**ALLIED HEALTH PROFESSIONAL STAFF**

**Delineation of Privileges**

**Radiation Therapist**

A Qualified Radiation Therapist is an individual who has successfully completed an accredited Radiation Therapy Program recognized by the American Registry of Radiologic Technologists.

**SCOPE OF PRACTICE:**

Radiation therapy involves treating disease with penetrating beams of high-energy radiation. For example, radiation therapy is used to treat cancer – alone or in conjunction with surgery and/or chemotherapy. Radiation therapists are highly skilled members of the cancer management team. They are responsible for accurately recording, interpreting and administering the treatment prescribed by radiation oncologists. During treatment, therapists help physicians use fluoroscopy, X-ray films or CT scans to localize and outline anatomical areas requiring treatment.

Radiation therapists have continual contact with patients for the course of their treatment, educating them about treatment and simulation procedures and potential radiation side effects. Monitoring and observing each patient’s clinical progress and emotional needs also are part of the therapist’s daily routine. The therapist, as a member of the health-care team, refers patients to physicians, nurses or social service professionals when necessary.

(R)= Requested (A)=Recommended as Requested (C)=Recommended with Conditions (N)=Not Recommended

(R)		(A)	(C)	(N)	Condition/Reason(s)
	<b>PRIVILEGES:</b>				
	Radiation Therapy				

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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name



**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, 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, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES  NO

If yes, please explain:

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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