



Core Privileges

DIAGNOSTIC RADIOLOGY

Qualifications (Core): M.D. or D.O. with current board certification from the American Board of Radiology or the American Osteopathic Board of Radiology, or its equivalent; or actively participating in the certification process leading to certification within five (5) years of completion of residency training. These privileges are to include the performance of any interventional techniques that are a natural extension of the designated procedure.

Applicants seeking renewal of privileges must meet ACR Practice Guidelines and Technical Standards for the particular diagnostic modality, performed the test or procedure in high enough volume that any quality trends might be detectable, and be engaged in the maintenance of certification (ABR-MOC) process for retaining diplomate status if initially board certified 10 years ago or longer.

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

Requested					
Yes	No	CORE DIAGNOSTIC RADIOLOGY:	(R)	(A)	(N) (C) Condition/Reason(s)
		Routine radiographic studies of the head, neck, spine, chest, abdomen, pelvis and extremities to include intravenous injection of contrast media			
		Fluoroscopic procedures of the gastrointestinal tract, e.g. intravenous barium swallow, enteroclysis, upper GI series, small bowel follow through, air contrast and solid column barium enemas			
		Radiologic procedures of the genitourinary tract, e.g., intravenous pyelogram, voiding cystourethrogram, hysterosalpingogram and nephrostogram			
		Radiologic procedures of the musculoskeletal system, e.g., arthrography, intra-articular aspirations and infusions			
		Nonvascular interventional procedures, e.g. percutaneous needle aspiration and biopsies, biliary, urologic, catheter drainage			
		Myelograms of the cervical, thoracic and lumbar spine via a lumbar puncture using fluoroscopic guidance			
		Nuclear medicine procedures using radioisotopes			
		Ultrasound examinations and ultrasound guided procedures including abdominal, small parts, vascular, pelvis and musculoskeletal ultrasound and neurosonology			
		Computed axial tomography images of the head, vascular system, neck, spine, chest, abdomen, pelvis and extremities			
		Magnetic resonance imaging studies of the vascular system, neck, spine, chest, abdomen, pelvis and extremities			
		SPECIAL PROCEDURES & IMAGING:			
		CT Angiography [<i>must meet ACCF/AHA requirements for training in cardiac CT</i>]			
		Mammography [<i>must show evidence of 906 readings in the past 24 months</i>]			
		Moderate sedation [<i>must show evidence of ACLS certification or have passed appropriate examination for the anesthetic drug listed</i>]			
		Teleradiology [<i>adherence to current ACR Practice Guidelines for Communication of Diagnostic Imaging Findings</i>]			

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



Core Privileges

INTERVENTIONAL RADIOLOGY

Successful completion of an approved residency program in diagnostic radiology followed by fellowship training, or its equivalent in interventional radiology.

The applicant must be able to demonstrate that he or she has 12 months of documented clinical practice devoted to interventional radiology and has performed at least 500 documented invasive cases (250 as primary operator) in the last 5 years in interventional radiology, including:

- 100 angiograms
- 25 angioplasties
- 15 nephrostomies

Core privileges include being able to admit, work up, diagnose, and provide treatment and consultative services to patients with a variety of conditions who may require vascular interventions such as:

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

Requested						
Yes	No	CORE interventional procedures:	(R)	(A)	(N)	(C) Condition/Reason(s)
		Balloon angioplasty				
		Arterial stent placement for stenosis or occlusion				
		Thrombolytic therapy				
		Other nonvascular interventional procedures:				
		Percutaneous nephrostomy				

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



Core Privileges

THERAPEUTIC RADIOLOGY

Qualifications: M.D. or D.O. with a minimum of 3 years residency training from an ACGME/AOA accredited Radiation Oncology Program, who currently qualifies to sit for the specialty board certification by the American Board of Radiology in Radiation Oncology or already holds subspecialty certification in Radiation Oncology, may be granted the following privileges in therapeutic radiation oncology.

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

(R)	PRIVILEGES:		(A)	(C)	(N)	Condition/Reason(s)
	External Beam					
	Brachy Therapy:					
		(1) Low dose rate (LDR)				
		a) Intracavitary				
		b) Interstitial				
		(2) High dose rate (HDR)				
		(3) Coronary Artery Brachy Therapy				
		(4) Prostate Brachy Therapy				
		(5) Transperineal interstitial permanent prostate brachytherapy				
	Sterotactic Radiosurgery					
	Treatment with Radio-pharmaceuticals					
		(1) Strontium				
		(2) P-32				
		(3) Pd 103				
		(4) I-25				
		(5) Other (specify) _____				
	Intraoperative Radiation Therapy (IORT)	(specify) _____				
	Other:	(specify) _____				

I hereby stipulate that I meet the minimum threshold criteria for the requested privileges and have requested only those privileges for which I am qualified to perform and wish to exercise at Teche Regional Medical Center. I acknowledge that I am bound by the applicable bylaws and policies of this hospital.

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:

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