

REHOBOTH MCKINLEY CHRISTIAN HOSPITAL (RMCH)

CLINICAL PRIVILEGES APPLICATION

RADIATION ONCOLOGY

APPLICANT NAME: \_\_\_\_\_

**CORE PRIVILEGES:**

Core privileges in radiation oncology include but are not limited to the following:

- Perform patient evaluations, which include patient histories and physical examinations
- Use diagnostic modalities, including x-ray, magnetic resonance imaging, and bone scan procedures
- Plan treatment, including selecting beam characteristics and/or the radionuclide sources, method of delivery, doses sequencing with other treatments, communication with and supervision of the medical physicist and dosimetrist
- Provide radiation oncology treatments, which include the following:
  - External beam therapy
  - Low dose rate brachytherapy
  - Teletherapy
  - Total body irradiation
  - Hyperthermia
  - Radiopharmaceutical therapy
- Formulate strategies to improve therapeutic response to treatment
- Assess treatment-related side effects
- Relieve or prevent treatment-related side effects or injury
- Follow-up irradiated patients on an inpatient or outpatient basis
- Provide pain management, which includes palliative and end of life care
- Develop, in association with the medical physicist and the radiation dosimetrist, standards for radiation safety and efficacy

**These privileges do not include any of the privileges listed under Special Privileges.**

**NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.**

**QUALIFICATIONS FOR CORE PRIVILEGES:**

**CLASS IV:**

\_\_\_\_\_ **Certification in Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited training program in radiation oncology.**  
Members with these privileges are expected to be physicians with experience, training and competence of service as consultants and treating extreme illnesses.

**CLASS III:**

\_\_\_\_\_ **Board certification in Radiation Oncology or Therapeutic Radiology by the ABR; or**  
\_\_\_\_\_ **Active board certification application pending, having completed an ACGME- or AOA approved post graduate training program in Radiation Oncology; or**  
\_\_\_\_\_ **Completion of an ACGME- or AOA-approved post graduate training program and full time Radiation Oncology experience for a minimum of the last three (3) years consecutively.**  
Members with these privileges are expected to be physicians with experience, training and competence in their specialty. Such

physicians would be expected to request consultation: (1) when hazardous treatment procedures are contemplated; (2) when unexpected complications arise; (3) or in cases in which treatment response seems unduly delayed.

**RADIATION/ONCOLOGY PRIVILEGES APPLICATION**

NAME: \_\_\_\_\_

Other training, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**EXPLANATION FOR REQUESTING PRIVILEGES:**

Listed below are the privileges appropriate for your specialty and location(s) of practice. If a privilege is desired that is not listed, please list it in the space designated. For all special privileges, an applicant is required to identify education and/or experience before privilege(s) will be evaluated.

**STANDARD PRIVILEGES:**

REQUESTED		RECOMMENDED	
Yes	No	Yes	No
___	___	___	___
Core Radiation/Oncology privileges (see page 1)			

**SPECIAL PRIVILEGES:** For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

REQUESTED		RECOMMENDED	
Yes	No	Yes	No
___	___	___	___
Stereotactic radiosurgery			
Training/Experience: _____			
___	___	___	___
High dose rate brachytherapy			
Training/Experience: _____			
___	___	___	___
Intensity modulated radiotherapy			
Training/Experience: _____			

**ADDITIONAL PRIVILEGES (Specify inpatient and/or outpatient, stated with training/experience):**

_____	___	___
_____	___	___
_____	___	___
_____	___	___

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 Rehoboth McKinley Christian Hospital and I understand that:

- (a) in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation
- (b) any restriction on the clinical privileges granted to me is waived in an emergency and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

RADIATION/ONCOLOGY PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

INPATIENT DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proctoring Arrangement: I have discussed the need for proctoring of this applicant. The following practitioner(s) who is/are member(s) of the Active Staff of the Medical Staff has/have been assigned:

\_\_\_\_\_

Signed: \_\_\_\_\_  
Medical Staff Department Chairperson

\_\_\_\_\_  
Date of Review

INTERNAL MEDICINE DEPARTMENT  
Medical Staff Department

Approved October 2006