

REHOBOTH MCKINLEY CHRISTIAN HOSPITAL
CLINICAL PRIVILEGES APPLICATION

RADIOLOGY

NAME: _____

CORE PRIVILEGES:

Privileges include supervision and interpretation of diagnostic radiology, diagnostic ultrasound, diagnostic nuclear medicine, diagnostic neuroradiology, and diagnostic body imaging. These privileges do not include any of the privileges listed as special requests.

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: (Check only the first one which applies to you)

CLASS IV:

___ **Certification in an Accreditation Council for Graduate Medical Education (ACGME)- or American Osteopathic Association (AOA)-approved subspecialty in Radiology.**

Subspecialty: _____.

Members with these privileges are expected to be physicians with experience, training and competence of service as consultants and treating the most extreme illnesses including those within the subspecialty area.

CLASS III:

___ **Board certification in Radiology; or**

___ **Active board certification application in Radiology pending, having completed an ACGME- or**

AOA-approved post graduate training program in Radiology; or

___ **Completion of an ACGME- or AOA-approved post graduate training program in Radiology and full time radiology experience for a minimum of the last six (6) 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.

Other training, please explain:

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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".

PRIVILEGES
 PRIVILEGES
 REQUESTED
 RECOMMENDED
 YES NO

YES NO

___ ___ Angioplasty - peripheral, renal, and visceral.

___ ___

Training/Experience: _____

___ ___ Diagnostic neuro, peripheral, and visceral arteriography.

___ ___

Training/Experience: _____

___ ___ Echocardiography interpretation

___ ___

Training/Experience: _____

___ ___ Image-guided percutaneous biopsies, aspirations, and drainage procedures.

Training/Experience: _____

___ ___ Intravenous conscious sedation.

___ ___

Training/Experience: _____

NOTE: ALL PRACTITIONERS GRANTED IV SEDATION PRIVILEGES MUST ADHERE TO PATIENT CARE SERVICES POLICY # 14.63.

___ ___ MRI Interpretation.

___ ___

Training/Experience: _____

___ ___ CT Interpretation.

___ ___

Training/Experience: _____

___ ___ Percutaneous endovascular stent placement.

___ ___

Training/Experience: _____

ADDITIONAL PRIVILEGES: (Specify, stated with training/experience):

___ ___
 ___ ___
 ___ ___

APPLICANT SIGNATURE: _____

DATE: _____

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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: _____
Department Chairperson

Date of Review

DIAGNOSTIC SERVICES DEPARTMENT.
Medical Staff Department

MSS:09/99.