Nuclear Medicine

Basic Education: M.D. or D.O.

Minimal Formal Training:

Category One privileges: Successful completion of an ACGME or AOA-approved residency training program in diagnostic radiology and including two (2) years of training in nuclear medicine. Experience includes performance of at least 100 nuclear medicine procedures during the past six months. Must be Board Eligible or Board Certified.

Category Two privileges: Successful completion of an ACGME or AOA-approved radiology residency including six-months to one year of experience with nuclear medicine. Must be Board Eligible or Board Certified.

Category Three privileges: Successful completion of a four-year ACGME-approved pathology residency including one year of radioisotopic pathology. Must be Board Eligible or Board Certified.

Core Privileges:

☐ **Category One**: Consultation, performance and interpretation of all routine and non-routine nuclear medicine procedures used to make diagnostic evaluations of the anatomic or physiologic conditions of the body by both in vivo and in vitro (non-imaging) techniques and to provide therapy with unsealed radioactive sources. Individuals qualified under Category One are also qualified under Two and Three.

☐ **Category Two**: Consultation, performance and interpretation of all routine and non-routine nuclear medicine procedures used to make diagnostic evaluations of the anatomic or physiologic conditions of the body by in vivo techniques only.

☐ **Category Three**: Consultation, performance and interpretation of all routine and non-routine nuclear medicine procedures used to make diagnostic evaluations of the anatomic or physiologic conditions of the body by in vitro techniques only.

Other privileges requested for which you have current clinical competency may be listed below. Documentation of training and/or experience must be provided for any special privileges requested. I understand that by making this request, I am bound by the applicable laws and policies of the Medical Center and hereby stipulate that I meet the minimum threshold criteria for this request.

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I understand that it is my obligation to notify the President of the Medical Staff of any procedure or mode of medical care in which I might engage that is not listed. I certify to the best of my knowledge, I am qualified and have professional liability insurance coverage for practice within the scope of privileges requested.

Signature ___________________________________ Date __________________