

# CARLSBAD MEDICAL CENTER

## RADIOLOGY APPLICATION FOR PRIVILEGES

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

BOARD CERTIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_

All practitioners requesting Radiology privileges are to be board certified by the American Board of Radiology or by the American Osteopathic Board of Radiology, or must be fully trained by an accredited Radiology residency program recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

CHECK EACH AREA FOR WHICH YOU ARE REQUESTING PRIVILEGES:

R = Requested                  G = Granted                  D = Denied

| PRIVILEGE LEVEL | PROCEDURAL PRIVILEGES   |
|-----------------|---|
| Level 1         | <b>USUAL AND CUSTOMARY RADIOLOGY PROCEDURAL PRIVILEGES</b><br>1) These procedural privileges are usually and customarily performed by board certified or fully trained Radiologists; and<br>2) Documentation of specific training and/or experience in Level 1 procedural privileges may be required; and<br>3) Level 1 procedural privileges are unasterisked. |

| PRIVILEGE LEVEL | PROCEDURAL PRIVILEGES  |
|-----------------|--|
| Level 2         | <b>ADVANCED RADIOLOGY PROCEDURAL PRIVILEGES</b><br>1) These procedural privileges may be performed by board certified or fully trained Radiologists; and<br>2) Level 2 procedural privileges require documentation of training and experience; and<br>3) Individual Level 2 procedural privileges must be proctored as defined on this application for privileges form; and<br>4) Level 2 procedural privileges are denoted by * (one asterisk). |

R = Requested                  G = Granted                  D = Denied

*NOTE: If applying for an asterisked (\*) privilege, enter the number and location of procedures performed in the last 2 years.*

R                  G                  D

#  
Performed                  Location Performed

**ANESTHESIA PROCEDURES**

**CONSCIOUS SEDATION**

|     |     |     |  |       |       |
|-----|-----|-----|--|-------|-------|
| [ ] | [ ] | [ ] | Pediatric (<15 years) Moderate Sedation* | _____ | _____ |
| [ ] | [ ] | [ ] | Adult Moderate Sedation*                 | _____ | _____ |
| [ ] | [ ] | [ ] | Pediatric (<15 years) Deep Sedation*     | _____ | _____ |
| [ ] | [ ] | [ ] | Adult Deep Sedation*                     | _____ | _____ |

CARLSBAD MEDICAL CENTER –APPLICATION FOR PRIVILEGES – RADIOLOGY

Name of Applicant: \_\_\_\_\_

**NUCLEAR MEDICINE—DIAGNOSTIC**

| R   | G   | D   |  | #<br>Performed | Location Performed |
|-----|-----|-----|--|----------------|--------------------|
| [ ] | [ ] | [ ] | Cardio   |                |                    |
| [ ] | [ ] | [ ] | Endocrine  |                |                    |
| [ ] | [ ] | [ ] | Gastrointestinal (including liver)                                 |                |                    |
| [ ] | [ ] | [ ] | Genitourinary  |                |                    |
| [ ] | [ ] | [ ] | Hematopoietic, Reticuloendothelial and Lymphatic, including spleen |                |                    |
| [ ] | [ ] | [ ] | Musculoskeletal  |                |                    |
| [ ] | [ ] | [ ] | Respiratory  |                |                    |
| [ ] | [ ] | [ ] | Vascular   |                |                    |

**NUCLEAR MEDICINE—THERAPEUTIC**

|     |     |     |                                   |
|-----|-----|-----|-----------------------------------|
| [ ] | [ ] | [ ] | Radioisotope Therapy – Injectable |
| [ ] | [ ] | [ ] | Radioisotope Therapy – Ingestible |

**ROUTINE IMAGING**

| R   | G   | D   |  |
|-----|-----|-----|--|
| [ ] | [ ] | [ ] | General Diagnostic:  |
| [ ] | [ ] | [ ] | Interpretation of films  |
| [ ] | [ ] | [ ] | Fluoroscopy  |
| [ ] | [ ] | [ ] | CT   |
| [ ] | [ ] | [ ] | Magnetic Resource Imaging  |
| [ ] | [ ] | [ ] | Ultrasound   |
| [ ] | [ ] | [ ] | Injection of Contrast  |
| [ ] | [ ] | [ ] | Arthrography (including joint aspiration and medication injection) |
| [ ] | [ ] | [ ] | Bronchography  |
| [ ] | [ ] | [ ] | Cystography  |
| [ ] | [ ] | [ ] | Hysterosalpingography  |
| [ ] | [ ] | [ ] | Mammography *  |
| [ ] | [ ] | [ ] | Myelography  |
| [ ] | [ ] | [ ] | Sialography  |
| [ ] | [ ] | [ ] | Urethrography  |

**SPECIAL PROCEDURES WITH  
CT FLUOROSCOPIC OR ULTRASONIC GUIDANCE OR MAGNETIC RESOURCE IMAGING  
ANGIOGRAPHY**

| R                    | G   | D   |  |
|----------------------|-----|-----|--|
| [ ]                  | [ ] | [ ] | Abdomen                                    |
| [ ]                  | [ ] | [ ] | Aorta                                      |
| [ ]                  | [ ] | [ ] | Carotid                                    |
| [ ]                  | [ ] | [ ] | Extremity                                  |
| [ ]                  | [ ] | [ ] | Pelvic                                     |
| [ ]                  | [ ] | [ ] | Pulmonary                                  |
| [ ]                  | [ ] | [ ] | Thoracic                                   |
| [ ]                  | [ ] | [ ] | Visceral                                   |
| [ ]                  | [ ] | [ ] | Cyst Aspiration, drainage and/or sclerosis |
| <b>NEEDLE BIOPSY</b> |     |     |  |
| [ ]                  | [ ] | [ ] | Breast                                     |
| [ ]                  | [ ] | [ ] | Bone                                       |
| [ ]                  | [ ] | [ ] | Lung                                       |
| [ ]                  | [ ] | [ ] | Liver                                      |
| [ ]                  | [ ] | [ ] | Kidney                                     |
| [ ]                  | [ ] | [ ] | Retroperitoneal                            |
| [ ]                  | [ ] | [ ] | Soft Tissue                                |
| [ ]                  | [ ] | [ ] | Thyroid                                    |
| [ ]                  | [ ] | [ ] | Paracentesis                               |

CARLSBAD MEDICAL CENTER -APPLICATION FOR PRIVILEGES - RADIOLOGY

Name of Applicant: \_\_\_\_\_

| R   | G   | D   |  | #         | Location Performed |
|-----|-----|-----|--|-----------|--------------------|
|     |     |     |  | Performed |                    |
| [ ] | [ ] | [ ] | Percutaneous Hepatic/Biliary Drainage Catheter Placement |           |                    |
| [ ] | [ ] | [ ] | Percutaneous Nephrostomy and/or Ureteral Stent Placement |           |                    |
| [ ] | [ ] | [ ] | Pericardiocentesis*                                      | _____     | _____              |
| [ ] | [ ] | [ ] | Thoracentesis  |           |                    |
| [ ] | [ ] | [ ] | Venography, inferior venacava and superior venacava      |           |                    |

**RADIATION ONCOLOGY**

|     |     |     |                                     |       |       |
|-----|-----|-----|-------------------------------------|-------|-------|
| [ ] | [ ] | [ ] | Consultation in Radiation Oncology* | _____ | _____ |
|-----|-----|-----|-------------------------------------|-------|-------|

**OTHER PROCEDURES**

|     |     |     |                 |       |       |
|-----|-----|-----|-----------------|-------|-------|
| [ ] | [ ] | [ ] | Specify: _____* | _____ | _____ |
| [ ] | [ ] | [ ] | Specify: _____* | _____ | _____ |

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

|                                  |           |      |
|----------------------------------|-----------|------|
| NAME OF APPLICANT (Please Print) | SIGNATURE | DATE |
|----------------------------------|-----------|------|

**APPROVALS**

All privilege delineations have been individually considered and have been recommended based upon the practitioner's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

(specify) \_\_\_\_\_

|                                 |      |
|---------------------------------|------|
| Medicine Department Chairperson | Date |
|---------------------------------|------|

|                             |      |
|-----------------------------|------|
| Medical Executive Committee | Date |
|-----------------------------|------|

|                   |      |
|-------------------|------|
| Board of Trustees | Date |
|-------------------|------|

**RADIOLOGY**  
**CRITERIA FOR CLINICAL PRIVILEGES**

Privileges followed by an asterisk (\*) are identified in this table. Please submit required documentation when applicable at the time of appointment or reappointment. The numbers indicated in this table represent the minimal number of documented procedures to be submitted for consideration of the advanced privilege requested. Additional documentation of training, experience and/or current competence may be requested and additional proctoring may be requested at any time by the Department Chairperson, or the Medical Executive Committee for any privilege requested.

| PROCEDURES   | TRAINING/EXPERIENCE   | Number of Documented Procedures for Initial Appointment | Number of Procedures Every 2 Years      | Number of Procedures to be Initially Proctored |
|--|---|---|---|--|
| <b>ANESTHESIA</b>  |   |   |   |  |
| Conscious Sedation – Pediatric (<15 years) Moderate Sedation or Analgesia                          | See Attachment C  | 2   | 1                                       | N/A  |
| Conscious Sedation – Adult Moderate Sedation or Analgesia  | See Attachment C  | 2   | 1                                       | N/A  |
| Conscious Sedation – Pediatric (<15 years) Deep Sedation or Analgesia                              | See Attachment C  | 2   | 1                                       | 4  |
| Conscious Sedation – Adult Deep Sedation or analgesia  | See Attachment C  | 2   | 1                                       | 4  |
| <b>ROUTINE IMAGING</b>   |   |   |   |  |
| Mammography  | Documentation of Successful Performance                                       | 240<br>(40 Hours of CME)                                | 40<br>Plus<br>(15 hours CME in 3 years) | N/A  |
| <b>SPECIAL PROCEDURES WITH CT FLUOROSCOPIC OR ULTRASONIC GUIDANCE OR MAGNETIC RESOURCE IMAGING</b> |   |   |   |  |
| Pericardiocentesis   | Documentation of Successful Performance                                       | 2   | 1                                       | 1  |
| <b>RADIATION ONCOLOGY</b>  |   |   |   |  |
| Consultation in Radiation Oncology   | Certification of training and proficiency by residency or fellowship program. | N/A   | N/A                                     | N/A  |

Name of Applicant: \_\_\_\_\_

Attachment C

**MEDICAL STAFF CREDENTIALING CRITERIA FOR CONSCIOUS SEDATION****Moderate Sedation or Analgesia**

Separate privileges are granted for the categories of adult and pediatric (< 15 years) moderate sedation or analgesia, based on documentation of current competency.

**All** medical staff requesting any conscious sedation privilege must complete and document a review of the current medical staff conscious sedation policy. **In addition** to the required review of the conscious sedation policy, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to the use of moderate sedation or analgesia, **and** successful performance of at least (1) moderate sedation/analgesia case in the last (2) years for each category of moderate sedation or analgesia applied for and (2) sedation/analgesia cases at initial appointment **OR**
2. Documentation of relevant training and experience **AND**
  - a. Attendance at a Carlsbad Medical Center sponsored CME program on moderate sedation/analgesia **or** review of the videotape of such conference **and** achievement of a score of 85% or higher on the moderate sedation/analgesia post-test, **AND** provisional privileges will be granted pending outcome review.

***Deep Sedation or Analgesia***

Separate privileges to be granted for the categories of adult and pediatric (< 15 years) deep sedation or analgesia based on documentation of current competency. **All** medical staff requesting any conscious sedation privilege, must complete and document a review of the current medical staff conscious sedation policy **AND** maintain current ACLS certification (*PALS or NALS as appropriate*); **OR** be Board Certified or fully trained in a Carlsbad Medical Center approved residency training program in Emergency Medicine, Anesthesiology or Critical Care Medicine.

In addition to the required review of the conscious sedation policy, ACLS and board certification or residency requirements above, practitioners requesting privileges in conscious sedation must meet requirements of either #1 **or** #2 listed below:

1. Documentation of training, experience and current competence related to use of deep sedation/analgesia, **and** successful performance of at least (1) deep sedation/analgesia cases in the last (2) years for each category of deep sedation or analgesia applied for **OR**
2. Documentation of relevant training and experience, **AND ALL** of the following:
  - a. Attendance at a Carlsbad Medical Center-sponsored CME program on deep sedation/analgesia or review of the videotape of such conference and achievement of the score of 85% or higher on the deep sedation/analgesia post-test, **AND**
  - b. Provide documentation of successful completion of four (4) deep sedation/analgesia cases, in each category applied for, under the direct supervision of a Carlsbad Medical Center practitioner holding appropriate clinical privileges in deep sedation. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement **AND**
  - c. Successful completion of four (4) intubations in the Operating Room under the direct supervision of a Carlsbad Medical Center credentialed anesthesiologist. If applying for both categories of deep sedation/analgesia, a total of six (6) cases will satisfy this requirement.

Attachment C



### **AUTHORIZATION FOR BACKGROUND CHECK**

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

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Print Name

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Signature

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Date