



## Radiology Privileges

**Printed Name:** \_\_\_\_\_

**Requested Staff Category:**     Active             Consulting             Courtesy             Locum Tenens             Allied Health

Active: Regularly admit patients or regularly involved in patient care & medical staff functions. Consulting: Member in good standing at another CMS or TJC accredited agency, non-voting staff member & cannot admit. Courtesy: Admits <13 patients/year & non-voting staff member. Locum Tenens: Assumes duties for the identified provider for whom they are covering (including ED Call) & limited to 90 days of coverage during a 12 month period. Allied Health: Licensed NP, CNS, PA, CRNA, RNFA, or Podiatrist & cannot admit.

**Life Threatening Emergency:** At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

**Basic Education:** MD or DO; Current NM License

**Minimal Formal Training:** Successful completion of any ACGME or AOA approved residency/fellowship in diagnostic radiology. Must be ABR or AOBR Board Eligible or Board Certified.

**Required Previous Experience:** Documentation or attestation of performance & interpretation of radiologic tests or procedures commensurate w/privileges requested during the past 2 years; specific requirements identified below.

**Core Privileges** Privileges to admit, diagnose, & consult through diagnostic workup planning, radiation monitoring, performing, & interpreting diagnostic procedures.

| Requested | Granted | Core Privileges include:   |
|-----------|---------|--|
|           |         | Routine radiographic studies including the head, neck, chest, abdomen, & extremities               |
|           |         | Computer tomography of the head, neck, chest, abdomen, extremities, & cardiovascular system        |
|           |         | Magnetic resonance imaging of the head, neck, chest, abdomen, extremities, & cardiovascular system |
|           |         | Fluoroscopic procedures  |
|           |         | Radiologic procedures of the genitourinary & gastrointestinal tracts                               |
|           |         | Radiologic procedures upon the musculoskeletal system  |
|           |         | Ultrasound procedures  |
|           |         | Advanced ultrasound procedures: endovaginal ultrasound, Doppler imaging of veins & arteries        |
|           |         | Diagnostic neuroradiology  |
|           |         | Emergency Department On-Call Coverage  |

**Additional Privileges:**

To be eligible to apply for a privilege listed below, you must meet the specified criteria, or be able to demonstrate, and/or document competence in performing any requested procedure. I understand that by making this request, I am bound by Artesia General Hospital's applicable bylaws and policies and hereby stipulate that I meet the minimum threshold criteria for this request.

| Requested | Granted | Privilege  |
|-----------|---------|--|
|           |         | Adult moderate sedation administration (in accordance with hospital policy)  |
|           |         | Pediatric moderate sedation administration (in accordance with hospital policy)  |
|           |         | Mammography & mammography interventional procedures (Meet ACR requirements; <u>minimum</u> reappointment requirement of 12 ultrasound-guided biopsies per year & 3 hours of Category 1 CME in ultrasound-guided breast biopsy every 3 years) |
|           |         | Mammography only (meet MQSA requirements; <u>minimum</u> appointment/reappointment requirement of 15 hrs Category I CME's in last 3 yrs of which 6 hrs in digital mammography is included.   |
|           |         | Diagnostic & therapeutic general angiography (Core + 1 yr special training or equivalent)  |
|           |         | Nonvascular interventional procedures (Core + 1 yr special training or equivalent)   |
|           |         | Neuroradiologic interventional procedures (Core + neuroradiology fellowship or equivalent required)  |

**Mammography & Mammographic Interventional Procedures**

This includes the following studies & procedures related to the breast: screening & diagnostic radiography, diagnostic ultrasonography, radiologically controlled needle localization, radiographic stereotatic fine needle biopsy/aspiration of lesions, & radiographic sterotatic core needle biopsy of lesions.

ACR Mammographic Intervention requirements include: Initially, 3 hours of Category 1 CME didactic instruction in ultrasound-guided biopsy and performance of at least three ultrasound-guided breast biopsy procedures under the supervision of a qualified physician. Completion of a residency or fellowship program that includes instruction in ultrasound-guided breast needle procedures is also acceptable. For maintenance of competence, the performance of at least 12 ultrasound-guided biopsies per year is recommended and 3 hrs of Category 1 CME in ultrasound-guided breast biopsy every 3 years. Documented experience must be submitted in a timely manner at application and reappointment.

**Diagnostic and Therapeutic General Angiography**

This includes all vascular studies, excluding those specifically defined to be in the province of neuroradiology & cardiac angiography, but including pulmonary angiography & extracerebral neck angiography, performed for the purpose of diagnosis or treatment using vascular needles or catheters. It includes therapeutic embolization & other forms of occlusion therapy, infusion therapies, & angioplasty.

**Nonvascular Interventional Procedure**

The procedures in this category include: image guided needle or nonvascular catheter procedures for biopsy, aspirations, and/or drainage; percutaneous bile duct dilation, stenting, & stone removal; percutaneous gallstone & renal stone removal; percutaneous urethral dilation & stenting; percutaneous gastrostomy or enterostomy; and other procedures requiring similar technical skills except for procedures on the breast which are included in Mammography.

**Neuroradiologic Interventional Procedures**

Includes invasive procedures which are done for the purpose of imaging the brain, orbital contents, spine, & spinal cord or involve entry into either the arterial or venous portions of these anatomic regions. Examinations limited to the extracerebral vasculature do not require neuroradiologic privileges. Also includes interventional neuroradiology of any of the above anatomical areas. This includes but is not limited to procedures such as vertebroplasties, dilatation, stenting, infusions, & embolizations.

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***I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and I wish to exercise these privileges at Artesia General Hospital. I understand that it is my obligation to notify the Chief of Staff of any procedure or mode of medical care in which I might engage that is not listed. I also acknowledge that my professional liability insurance extends to all privileges I have requested. I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff bylaws, policies and rules applicable generally and any applicable to the particular situation.***

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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***I have reviewed the requested clinical privileges and supporting documentation for the above named practitioner and recommend action on the privileges as noted above.***

**Medical Staff Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## CONFIDENTIALITY STATEMENT

I, \_\_\_\_\_, understand that in performance of my duties at Artesia General Hospital, I am required to have access to and am involved in the processing of patient care data. I understand that I am obligated to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subject to legal action. I agree to comply with information security policies for Artesia General Hospital concerning the privacy and confidentiality consideration of patient care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**MEDICAL STAFF SIGNATURE AUTHENTICATION FORM**

Medicare regulation 482.24, authentication of signature, requires that the medical records department maintain a current list of authenticated signature, written initials, codes and stamps, when such are used for authorship.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Initials

**Approved Signature Stamps or Seals:**

Original: Credential File  
CC: Pharmacy, Medical Records



**PHYSICIAN'S ACKNOWLEDGEMENT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to obtain a signed *Physician's Acknowledgement Statement* from any physician who is being granted admitting privileges at that Hospital.

Your signature acknowledges that you have received the following notice [42 CFR 41246 (b)]:

*Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.*

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
UPIN/NPI #



**BYLAWS ACKNOWLEDGEMENT OF RECEIPT**

I, \_\_\_\_\_, acknowledge that I have read and understood the Medical Staff Bylaws, Rules and Regulations of Artesia General Hospital.

Furthermore, I agree to abide by all such Bylaws, Rules and Regulations, Hospital Policies and Directives during the time I remain appointed to the Medical Staff or Allied Health Professional Staff of Artesia General Hospital.

\_\_\_\_\_  
**Physician Name and Title (PRINTED)**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature