



Delineation Of Privileges
Radiation Oncology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved
-----------	-----------	--------	----------

RADIATION ONCOLOGY PRIVILEGES - CATEGORY I

Criteria:

- a) Board Certification or qualified for certification by the American Board of Radiology; OR,
- b) Successful completion of an approved training program requiring Certification by a Training Director regarding experience and demonstrated competence to perform the procedure(s) being requested.

Proctoring Requirements: A minimum of eight (8) cases, in accordance with the Medicine Department Rules and Regulations.

GENERAL PRIVILEGES:

Consultation Only privileges ___ ___ ___

Sedation Analgesia ___ ___ ___

Criteria: Requires successful completion of the Sedation Assessment Test.

Additional criteria effective April 1, 2015: a) Evidence of current ACLS and/or PALS certification from the American Heart Association; AND b) Evidence of completion of an Airway Management Course

a) Adult Sedation ___ ___ ___

b) Pediatric Sedation (17 years and under) ___ ___ ___

RADIATION ONCOLOGY - CATEGORY I PRIVILEGES

Includes the management and coordination of care, treatment and services, including: Medical history and physical examinations, consultations and prescribing medication in accordance with DEA certificate.

Radiation treatment plan, orthovoltage ___ ___ ___

Radiation treatment plan, megavoltage ___ ___ ___

Interpretation CT local scan for radiation therapy ___ ___ ___

Simulation with fluoroscopy ___ ___ ___

Design of treatment devices ___ ___ ___

Supervision of Radiation Physicist ___ ___ ___



Delineation Of Privileges
Radiation Oncology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved
-----------	-----------	--------	----------

Review of port films	—	—	—
Calculation of radiation doses	—	—	—
Supervision of tele and brachy-isodose plans	—	—	—

RADIATION ONCOLOGY - CATEGORY 2

Criteria: Must meet the criteria outlined for Category I Radiation Oncology Privileges, AND, provide evidence of the successful completion of an approved training course focusing on or specifically including the procedure(s) for which privileges are requested.

Proctoring Requirements: A minimum of one case for each Category 2 privilege requested.

Special radiation treatment plans:

a) Electron therapy	—	—	—
b) Total body radiation and hemibody	—	—	—
c) Endo orthovoltage therapy	—	—	—
Intracavitary insertions	—	—	—
Interstitial applications	—	—	—
I-131 treatment of Hyperthyroidism	—	—	—
I-131 ablation for thyroid cancer	—	—	—
Infusion of radioelements	—	—	—

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at Huntington Hospital, and I understand that: a) in exercising my 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 situation and in such a situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.



Delineation Of Privileges
Radiation Oncology Privileges

Provider Name:

Privilege	Requested	Tabled	Approved
-----------	-----------	--------	----------

Signature of Applicant: _____ **Date:** _____

DEPARTMENT CHAIR RECOMMENDATIONS

I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and recommend action on the privileges as noted above.

Applicant may perform privileges and procedures as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

APPROVALS:

Section Chair: _____ **Date:** _____

Department Chair: _____ **Date:** _____

Credential Committee Date: _____

Medical Executive Committee Date: _____

Board of Directors Approved on: _____