Huntington Hospital

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, othovoltage	___	___	___
Radiation treatment plan, megavoltage	___	___	___
Interpretation CT local scan for radiation therapy	___	___	___
Simulation with fluoroscopy	___	___	___
Design of treatment devices	___	___	___
Supervision of Radiation Physicist	___	___	___

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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	___	___	___
Intersitial 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.

Huntington Hospital

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: _____