

CRITERIA FOR GRANTING RADIOLOGY PRIVILEGES

Please review these categories carefully to determine those privileges for which you are qualified. Indicate your request below by checking the appropriate category. If you feel that special training or experience qualifies you for advanced privileges, please contact the appropriate department chair.

All members of the Department of Radiology must be eligible for examination or certified by the American Board of Radiology, or possess such expertise by virtue of training and experience that are acceptable to and in accordance with the standards of this department.

Name: _____

Appointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be proctored by a member of the Active Staff who has been granted the privilege.

Reappointment: A minimum of three (3) cases of any of the following elective procedures **MUST** be performed within the past two years. If this is not met, the request will be evaluated and monitoring may be re-assigned.

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	GENERAL RADIOLOGY	APPROVED	DENIED
<input type="checkbox"/>	_____	Diagnostic Radiology (Radiology (interpretation))	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Computerized Tomography	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	MRI	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Diagnostic Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>

Please check the privilege(s) you are requesting and the approximate # performed in the last 2 years:

REQUESTED	# PERFORMED IN LAST 2 YEARS	SPECIALIZED PROCEDURES	APPROVED	DENIED
<input type="checkbox"/>	_____	Arteriography	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Venography	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Myelography/Discography	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Biopsy/Aspiration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Injection of Contrast Medium	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Tube Drainage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Insertion of Vena Cava Filters	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Percutaneous Placement of Vascular Catheter	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Galactography	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Intracavity Injection of Contrast	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	_____	Arthrography	<input type="checkbox"/>	<input type="checkbox"/>

Foothill Presbyterian Hospital
 Radiology Privileges Request Form
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|--------------------------|-------|--|--------------------------|--------------------------|
| <input type="checkbox"/> | _____ | Hysterosalpingography &
Sonohysterography | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | Angiodynography (non-invasive
vascular studies) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | Fluoroscopy | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | Arterial Duplex Scan Extremities | <input type="checkbox"/> | <input type="checkbox"/> |

(OTHER PROCEDURES NOT LISTED)

- | | | | | |
|--------------------------|-------|-------|--------------------------|--------------------------|
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> |

PROCTORING REQUIREMENTS: *It is the responsibility of the physician doing the procedure to obtain proctor forms and to ensure that the proctoring report is forwarded to the Medical Staff Office. A physician will be removed from the proctoring program when the reports have been reviewed by the Medical Department and the physician is so notified. If, at the time of reappointment, certain procedures have not met the required number to be performed within the past two years, monitoring may be assigned.*

On the basis of my training and experience, I am qualified to exercise and request the privileges which I have checked.

I have not requested privileges for any procedures for which I am not qualified. I am familiar with the laws of the State governing the practice of medicine and pledge to abide by these laws.

PRIVILEGES APPROVED: /__ / AS REQUESTED /__ / AS MODIFIED BELOW

Applicant's Signature: _____ **Date:** _____

Medical Department Chair _____ **Date:** _____

fphrad1
 6/06, 7/08, 8/09