NAME ____________________________

Fort Hamilton Hospital
Specialty: Radiology – Radiation Oncology
Delineation of Privileges

Instructions:
1. Check the Request checkbox to request all privileges in the Core group.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign/Date form and Submit with required documentation.

Required Qualifications

Education/Training/Experience
Must have successfully completed an ACGME/AOA-accredited residency in radiation oncology. The successful applicant for initial appointment must provide documentation of performance of at least 125 irradiation procedures, reflective of the scope of privileges requested, in the past 12 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship or research in a clinical setting within the past 12 months.

Certification
The applicant physician must possess current board certification by the specialty board most commonly applicable to his or her specialty, or become board certified as such within six years of completing his or her residency program or receiving medical staff membership or clinical privileges.

Reappointment Criteria of Radiation Oncology Core Privileges
To be eligible to renew core privileges in Radiation Oncology, the applicant must demonstrate competence and an adequate volume of experience (125 irradiation procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.
CORE PRIVILEGES IN RADIATION ONCOLOGY

Core Privileges include: Admit and provide comprehensive (multidisciplinary) evaluation and treatment planning for patients with cancer, related disorders, and therapeutic radiation for benign diseases, and consult on patients. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures below and such other procedures that are extensions of the same techniques and skills.

Request all privileges listed below. Uncheck any privileges that you do not want to request.

- Admit and manage patients in non-critical care and unmonitored settings
- Perform History and Physical Examinations
- Consultation privileges in Radiation Oncology
- Administration of drugs and medicines related to radiation oncology and cancer supportive care
- Administration of radiosensitizers, radioprotectors under appropriate circumstances
- Combined modality therapy (e.g., surgery, radiation therapy, chemotherapy, or immunotherapy used concurrently or in a timed sequence)
- Computer assisted treatment simulation and planning (external beam therapy and radioactive implants)
- Electron beam radiotherapy
- Fractionated stereotactic radiotherapy
- Linear accelerator radiotherapy – photon & electron
- Orders and utilizes X-ray, ultrasound, CT, MRI and PET, to assist in treatment planning
- Placement of catheters, IV’s, IV contrast dye and radiopaque devices that pertain to treatment planning
- Radiation prescription of doses, treatment volumes, field blocks, molds and other special devices for external beam therapy
- Radiation therapy by external beam (photon and electron irradiation)
- Stereotactic radiosurgery

Acknowledgement of Applicant

I hereby request the clinical privileges in the Department of Radiology as indicated. I understand that such privileges include rendering of all associated diagnostic and supportive measures necessary in performance of the privileges I have requested, and in treating associated diseases with adequate consultation when indicated.

I recognize that in emergency situations where immediate life-saving action is necessary, any member of the medical staff is authorized to perform such life-saving treatment as may be required.

I further understand that any and all privileges granted me in the Department of Radiology shall be commensurate with my documented training and demonstrated competence, judgment and capabilities. The Credentials and Executive Committees of the medical staff and the Board of Trustees of the hospital reserve the right to grant or limit my privileges in accord with my continuing performance in rendering patient care.

Practitioner’s Signature ___________________________ (Date) ___________________________

Print Name ___________________________