

**Regions Hospital
Delineation of Privileges
Radiation Therapy**

Applicant's Name: _____
Last
First
M
Date

Instructions: Applicants must provide complete names and addresses for their references. **Please DO NOT SEND letters of recommendation along with your application.** These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

CORE I - General Privileges Radiation Therapy (This box must be checked if you desire any of the privileges listed below)

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include admitting privileges, H&P, diagnosis and care of oncology patients, evaluation, treatment, and planning for applications of ionizing radiation of the management of both benign and malignant diseases. Management and treatment of radiation induced side effects (i.e., CNS, pulmonary, skin, and gastrointestinal toxicities). Administration of intracavitary and intravascular contrast material. Management of allergic reactions to contrast materials.</p>	<p>M.D. or D.O., MBBS</p> <p><u>AND</u></p> <p>Training in radiation oncology (4 years in radiation oncology, or a 3-year residency with a 1-year fellowship in radiation oncology)</p> <p><u>AND</u></p> <p>Board Certified by the American Board of Radiology with a specialty in therapeutic radiology.</p>	<p><u>New Applicants:</u></p> <p>Documentation of primary or consultative service in radiation oncology for at least twenty-five (25) patients in twelve (12) months AND</p> <p>Name and address of another radiation oncologist who can comment on the applicant's current clinical competence to perform these privileges OR</p> <p>Name and address of the Program Director where the applicant trained who can comment on the applicant's current clinical competence to perform the privileges requested. Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <p>If the applicant is <u>not board certified</u> in Therapeutic Radiology, documentation of the provision of at least twenty-five (25) patients in twelve (12) months is required OR</p> <p>If the applicant <u>is board certified</u> in Therapeutic Radiology, evidence of continued board certification is required AND</p> <p>Name and address of another radiation oncologist who can comment on current clinical competency to perform privileges requested. Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____</p>

CORE II- Special Privileges Radiation Therapy (This box must be checked, in addition to checking the specific privileges, if you desire any of the privileges listed below)

Procedures	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Radioactive isotope administration (Contact Therapy) <input type="checkbox"/> Radioactive pharmaceutical drug administration (Intravascular or Intraperitoneal) <input type="checkbox"/> Radioactive interstitial iodine <input type="checkbox"/> Radioactive isotope, interstitial or intracavity brachytherapy	Same criteria as Core I privileges.	<p><u>New Applicants:</u></p> <p>Documentation of primary or consultative service in radiation oncology for at least twenty-five (25) patients in twelve (12) months</p> <p><u>AND</u></p> <p>Name and address of another radiation oncologist who can comment on the applicant's current clinical competence to perform these privileges;</p> <p><u>OR</u></p> <p>Name and address of the Program Director where the applicant trained, who can comment on the applicant's current clinical competence to perform the privileges requested.</p> <p>Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____</p> <p><u>Reappointment Applicants:</u></p> <p>If the applicant is <u>not board certified</u> in Therapeutic Radiology, documentation of the provision of at least twenty-five (25) patients in twelve (12) months is required</p> <p><u>OR</u></p> <p>If the applicant <u>is board certified</u> in Therapeutic Radiology, evidence of continued board certification is required</p> <p><u>AND</u></p> <p>Name and address of another radiation oncologist who can comment on current clinical competency to perform the privileges requested.</p> <p>Name: _____ Name of Facility: _____ Address: _____ Ph/Fax: _____</p>

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. If the information is not received within the allowable timeframe as outlined within the Medical Staff Credentialing Policies & Procedures, I understand that the process will be stopped until such time that I submit the required documentation.

Signature

Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Signature

Date