



Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
		<p><b><u>Reappointment Applicants:</u></b>  Name and address of another radiologist that can attest to current clinical competency  Name: _____  Add: _____  Ph/Fax: _____</p> <p><b><u>PLUS</u></b>  Documentation of any additional training or certifications received in the interval from the previous application.</p>

**CORE II - Special Privileges Radiology (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"/> Cardiac Cine Angiograms  <input type="checkbox"/> Diagnostic Neuro, Peripheral and Visceral Arteriography	Same as Core I	<p><b><u>New Applicants:</u></b>  Documentation of successful completion of at least thirty (30) cardiac cine angiograms or diagnostic neuro, peripheral and visceral arteriography within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested.  Name: _____  Add: _____  Ph/Fax: _____</p> <p><b><u>Reappointment Applicants:</u></b>  Documentation of successful completion of at least fifteen (15) cardiac cine angiograms, or diagnostic neuro, peripheral or visceral arteriograms within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested.  Name: _____  Add: _____  Ph/Fax: _____</p>
<input type="checkbox"/> Angioplasty & Percutaneous Stent Placement (Peripheral, Renal and Visceral)	Same as Core I	<p><b><u>New Applicants:</u></b>  Documentation of successful completion of at least fifteen (15) procedures within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested.  Name: _____  Add: _____  Ph/Fax: _____</p>

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Angioplasty & Percutaneous Stent Placement (Peripheral, Renal and Visceral)	Same as Core I	<p><b><u>Reappointment Applicants:</u></b> Documentation of successful completion of at least ten (10) procedures within the past twelve (12) months</p> <p><b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested. Name: _____ Add: _____ Ph/Fax: _____</p>
<input type="checkbox"/> Percutaneous Biopsies, Aspirations and Drainage Procedures	Same as Core I	<p><b><u>New Applicants:</u></b> Documentation of successful completion of at least twenty (20) procedures within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested. Name: _____ Add: _____ Ph/Fax: _____</p> <p><b><u>Reappointment Applicants:</u></b> Documentation of successful completion of at least ten (10) procedures within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested. Name: _____ Add: _____ Ph/Fax: _____</p>
<input type="checkbox"/> Percutaneous Neurointerventional Procedures	Same as Core I	<p><b><u>New Applicants:</u></b> Documentation of successful completion of at least three (3) procedures within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested. Name: _____ Add: _____ Ph/Fax: _____</p>

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<input type="checkbox"/> Percutaneous Neurointerventional Procedures	Same as Core I	<p><b><u>Reappointment Applicants:</u></b>            Documentation of successful completion of at least three (3) procedures within the past twelve (12) months <b><u>OR</u></b></p> <p>Name and address of a physician whom we may contact to comment on your current clinical competence to perform the procedure(s) requested.            Name: _____            Add: _____            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. I also understand that my application for privileges will not proceed until which time that the information is received.

\_\_\_\_\_  
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

# *Regions Hospital Delineation of Privileges Conscious Sedation*

**Applicant's Name:** \_\_\_\_\_  
Last
First
M
Date

**Instructions:** In order to be eligible to request clinical privileges to administer conscious sedation, a practitioner's must meet the following basic education & minimal formal training and the requirement documentation and experience.

**Conscious Sedation**

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>Privileges include being able to administer and manage moderate sedation/analgesia (Conscious Sedation): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.</p>	<ol style="list-style-type: none"> <li>1. MD, DO, MBBS, DPM, DMD, DDS,</li> <li>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program.</li> </ol>	<p><u>Initial Applicants:</u></p> <ol style="list-style-type: none"> <li>1. All applicants must be able to demonstrate competence for moderate sedation/analgesia (i.e. conscious sedation) must have the skills to rescue patients who enter a state of deep sedation/analgesia.</li> <li>2. Each member applying for conscious sedation privileges will be required to document successful completion of an examination, provided by the medical staff services @ Regions at initial appointment or provide evidence of experience by meeting one of the following: <ul style="list-style-type: none"> <li>• Copy of test and passing score from another hospital</li> <li>• Copy of governing board letter indicating the applicant has conscious sedation privileges at another hospital</li> <li>• Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has conscious sedation privileges and the date they were granted</li> <li>• Recent graduates must provide attestation of competency from their program director</li> </ul> </li> </ol> <p><u>Reappointment Application:</u></p> <ul style="list-style-type: none"> <li>• Successful applicant must be able to demonstrate that he/she has performed procedural sedation for at least ten (10) patients during the past twenty-four (24) months</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• documentation from his/her Division/Section Head of ongoing current competence</li> </ul>

**TO BE COMPLETED BY APPLICANT:**

I understand that in making this request I am bound by the applicable Bylaws and policies of the Hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

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. I also understand that my application for privileges will not proceed until which time that the information is received.

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Signature

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Date

**TO BE COMPLETED BY DIVISION/SECTION HEAD:**

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.

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Signature

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Date