

**Regions Hospital
Delineation of Privileges
Radiology/Emergency Services/Imaging Center**

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 – Privileges to Provide Emergency Services (This box must be checked if you desire privileges listed below)

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
<p>To provide emergency services to include stabilization and treatment in setting of acute reaction that may be encountered in Imaging Center.</p> <p>This does not include performance or interpretation of radiological studies.</p>	<p>M.D. or D.O., MBBS <u>AND/OR</u> Currently enrolled in an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program. <u>AND</u> Current ACLS certification</p>	<p><u>New Applicants:</u> Names and addresses of two (2) <u>physician colleagues</u> whom we may contact who can comment on the applicant's current clinical competence to perform the privileges requested. Name: _____ Name of Facility: _____ Add: _____ Phone/Fax: _____</p> <p>_____ Name: _____ Name of Facility: _____ Add: _____ Phone/Fax: _____</p> <p><u>Reappointment Applicants:</u> 1. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact. Name: _____ Name of Facility: _____ Add: _____ Phone/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