Regions Hospital
Delineation of Privileges
Radiation Oncology

Applicant's Name: _____
Last First M.

Instructions:
- Place a check-mark where indicated for each core group you are requesting.
- Review *education and basic formal training* requirements to make sure you meet them.
- Review *documentation and experience* requirements and be prepared to prove them.
  - ✓ Note all renewing applicants are required to provide evidence of their current ability to perform the privileges being requested
  - ✓ When documentation of cases or procedures is required, attach said case/procedure logs to this privileges-request form.
- Provide complete and accurate names and addresses where requested -- it will greatly assist how quickly our credentialing-specialist can process your requests.

Overview

Core I – General privileges in radiation therapy
Core II – Privileges in breast brachytherapy
Core III – Privileges in stereotactic radiosurgery
Core procedure list
Signature page

☐ CORE I — General privileges in radiation oncology

Privileges

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 of all ages.

The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Basic education and minimal formal training

1. MD DO, MBBS or MB BCH.
2. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in radiation oncology.
3. Current certification by the American Board of Radiology or the American Osteopathic Board of Radiology, or active participation in the examination process with achievement of certification within 5 years in radiation oncology.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of primary or consulting services in radiation oncology for at least 25 patients in 12 months.
2. Provide contact information for another radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

   Or

   Provide contact information for the program director where training occurred whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

REAPPOINTMENT APPLICANTS:

1. If applicant IS NOT board certified in radiation oncology, provide documentation of primary or consulting services in radiation oncology for at least 25 patients in 12 months.
2. Provide contact information for another radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

☐ CORE II — Privileges in breast brachytherapy

Privileges

Breast brachytherapy.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in radiation oncology.
3. Current certification by the American Board of Radiology or the American Osteopathic Board of Radiology, or active participation in the examination process with achievement of certification within 5 years, in radiation oncology.
4. Completion of a course in breast brachytherapy and experience training in the radiation therapy system to be used.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of primary or consulting services in radiation oncology for at least 25 patients in 12 months of which at least 20 involve performance of a breast brachytherapy procedure.
2. Provide contact information for another radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

   Or

   Provide contact information for the program director where training occurred whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

   Name: _____

   Name of Facility: _____

   Address: _____

   Phone: _____ Fax: _____

   Email: _____

REAPPOINTMENT APPLICANTS:

1. If applicant IS NOT board certified in radiation oncology, provide documentation of primary or consulting services in radiation oncology for at least 25 patients in 24 months.
2. Provide contact information for another radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

   Name: _____

   Name of Facility: _____

   Address: _____

   Phone: _____ Fax: _____

   Email: _____

☐ CORE III — Privileges in sterotactic radiosurgery

Privileges

Sterotactic radiosurgery.

Basic education and minimal formal training

1. MD, DO, MBBS or MB BCH.
2. Successful completion of an accredited residency in radiation oncology for Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
3. Current certification in therapeutic radiology or radiation oncology by the American Board of Radiology or the American Osteopathic Board of Radiology, or active participation in the examination process with achievement of certification within 5 years.
4. Accredited residency in radiation oncology must have included training in sterotactic radiosurgery (SRS);
   Or
   Evidence of completion of an approved training program in radiosurgery.
5. Training and experience with the specific delivery system to be used.

Required documentation and experience

NEW APPLICANTS:

1. Provide documentation of primary or consulting services in radiation oncology for at least 3 patients in 12 months involving performance of a radiosurgery procedure;
   Or
   Provide evidence of proctoring by an experienced radiosurgery physician for 3 cases.
2. Provide contact information for a radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence;
   Or
   Provide contact information for the program director where training occurred whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

REAPPOINTMENT APPLICANTS:

1. If applicant IS board certified in radiation oncology, provide documentation of primary or consulting services in radiation oncology for at least 6 patients in 24 months, of which at least 3 involve performance of a radiosurgery procedure.
2. If applicant <u>IS NOT board certified</u> in radiation oncology, provide documentation of primary or consulting services in radiation oncology for at least 6 patients in 24 months of which at least 3 involve performance of a radiosurgery procedure;
   And
   Provide contact information for a radiation oncologist whom the credentialing specialist may contact to provide an evaluation of your clinical competence.

Name: _____

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Core I Procedure List — Radiation Oncology Clinical Privileges

To the applicant: If you want to exclude any procedures, please strike though those procedures you do not wish to request.

This list is a sampling of procedures included in the core. This is not intended to be all-encompassing but rather reflective of the categories/types of procedures included in the core.

1. Administration of drugs and medicines related to radiation oncology and cancer supportive care
2. Administration of radiosensitizers, radioprotectors under appropriate circumstances
3. Brachytherapy both interstitial and intracavitary and unsealed radionuclide therapy
4. Combined modality therapy (e.g., surgery, radiation therapy, chemotherapy, or immunotherapy used concurrently or in a timed sequence)
5. Computer assisted treatment simulation and planning (external beam therapy and radioactive implants)
6. Fractionated sterotactic radiotherapy
7. Immunotherapy
8. Intraoperative radiation therapy
9. Interpretation of studies as they pertain to neoplastic or benign conditions
10. Perform history and physical exam
11. Placement of catheters, IV's, IV contrast dye and radiopaque devices that pertain to treatment planning
12. Radiation prescription of doses, treatment volumes, field blocks, molds and other special devices for external beam therapy
13. Radiation therapy by external beam (photon and electron irradiation)
14. Radiation therapy contact therapy (SR, molds, etc.)
15. Radioactive isotope therapy: intraperitoneal, intracavitary, interstitial, intraluminal implantation, regional and systemic, and intravenous, radioactive antibody therapy
16. Total body irradiation
17. X-ray, ultrasound, CT, MRI, and PET, assisted treatment planning

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.
2. In an emergent situation I may perform a procedure for which I am not privileged when no practitioner holding the applicable procedure is available to respond to the emergency.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until the information is received.

_____ _____

Signature Date

DIVISION / SECTION HEAD RECOMMENDATION

I have reviewed and/or discussed the clinical privileges requested and supporting documentation for the above-named applicant and make the following recommendation/s:

☐ Recommend all requested privileges

☐ Recommend privileges with the following conditions/modifications

☐ Do not recommend the following requested privileges

Privilege	Condition / Modification / Explanation
1.	
2.	
3.	
4.	

Notes:

_____ _____

Signature Date