LAC+USC MEDICAL CENTER ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF RADIOLOGY
PHYSICIAN ASSISTANTS

NAME OF APPLICANT _____ **DATE**_____

☐ Initial Appointment and/or Additional Privileges ☐ Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair/Chief/Designee: Initial the Recommended column for approved privileges. If applicable, check off the "Not Recommended" boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	Physician Assistant's (PA) , in accordance with the Delegation of Services Agreement between the PA and the Supervising Physician, may provide any legal medical service that is within the PA's scope of medical practice. **Core Privileges**: Basic privileges in Radiology include: - Institute treatment essential for the life of the patient (e.g., BCLS), - Transfer patients to observation areas and between hospital units, - Obtain a history, - Perform a physical examination, - Order laboratory and diagnostic procedures, - Interpret laboratory data, - Interpret diagnostic studies, - Obtain informed consent for procedures, - Perform and/or assist in the performance of diagnostic studies within the scope of specialty services, - Perform and/or assist in the performance of therapeutic procedures within the scope of specialty services, - Monitor patients throughout procedure and during recovery period, - Determine assessment and interval for follow up, - Conduct patient and family education, - Manage and provide consultations, - Document patient interactions, - Document care rendered in medical record, and - Complete discharge summaries of patients. for the following ages:			

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other
	Neonates and Infants from 0 to 2 years of age			
	Children from 3 to 13 years of age			
	Adolescents and Adults 14 years of age and older			
	Transmittal of written orders for medications and medical devices			
	AREA OF SPECIALIZATION			
	Radiology			
	SPECIFIC PRIVILEGES			
	1. Percutaneous breast biopsy			
	2. Local anesthesia			
	3. Breast cyst/diagnostic aspiration			
	4. Sterotactic breast biopsy			
	5. Ultrasound guided percutaneous core breast biopsy			
	6. Pre-operative needle localization			
	7. Ductogram (breast)			

Name: _____

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other

PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and 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 in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

_____ _____

Applicant's Signature Date

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_____ _____ _____

Supervising Physician (print) (Signature) Date

Name: _____

REQUESTED	DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
LAC+USC Medical Center			Competency	Other

Department Chair/Chief/Designee recommendation:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege#:_____
Condition/Modification/Explanation:_____
_____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege#:_____
Explanation for NOT recommending based on
COMPETENCY:_____
_____

If supplemental documentation provided, check here: ☐

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

_____ _____
SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE **DATE**

APPROVED BY INTERDISCIPLINARY PRACTICE COMMITTEE ON:	APPROVED BY EXECUTIVE COMMITTEE ON:
APPROVED BY GOVERNING BODY ON:	PERIOD ENDING:

Name: _____