

**LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
 DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF RADIATION ONCOLOGY**

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	
M	E	H	R			Competency	Other
				Core Privileges in Radiation Oncology: includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans for the following ages:			
				Neonates and Infants ages 0 to 2 years of age			
				Children ages 3 to 13 years of age			
				Adolescents and Adults 14 years of age and older			
				1. Teletherapy:			
				• Megavoltage (4MeV beam)			

M = LAC+USC Medical Center
 E = El Monte Comprehensive Health Center
 H = Hudson Comprehensive Health Center
 R = Roybal Comprehensive Health Center

REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Supervoltage (10 and 23 MeV beam)			
				• Orthovoltage (superficial and deep)			
				2. ELECTRON BEAM THERAPY (4 MeV through 25 Mev)			
				3. BRACHYTHERAPY			
				• Intracavitary gynecological			
				• Intracavitary gynecological			
				• Intracavitary head and neck			
				• Intracavitary - (other, please specify) _____			
				• Interstitial			
				4. SIMULATION and Treatment Planning			
				5. HYPERTHERMIA (includes superficial, deep, interstitial, and intracavitary)			
				6. ENDOSCOPY (both rigid and flexible):			
				• Upper respiratory and air passages			
				• Proctosigmoidoscopy			
				MODERATE/DEEP SEDATION PRIVILEGES			

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M	E	H	R			Competency	Other
				DECLARATION OF BRAIN DEATH PRIVILEGES			
				TEACHING ONLY			

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

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M	E	H	R			Competency	Other

Department Chair/Chief/Designee:

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 CREDENTIALS & PRIVILEGES COMMITTEE ON:

APPROVED BY EXECUTIVE COMMITTEE ON:

APPROVED BY GOVERNING BODY ON:

PERIOD ENDING:

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