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

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 Radiology: includes performing a history and physical, interpreting laboratory studies, interpreting and performing diagnostic studies and treatment plans for the following ages:			
				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			
				CATEGORY I			
				1. GENERAL RADIOLOGY			
				• Plain Film Interpretation			
				• Use of Fluoroscopy, requires a California Radiology Supervisor and Operator Certificate.			
				2. GASTROINTESTINAL			
				• Upper GI contrast studies			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Contrast enema studies			
				• Other GI contrast studies			
				• Tube placement			
				• Sinogram			
				• Fistulous tract injection			
				• T-tube cholangiography			
				• ERCP (Interpretation)			
				3. GENITO-URINARY			
				• Intravenous pyelography			
				• Cystography			
				• Loopogram			
				• Urethrography			
				• Voiding Cytography			
				4. MULTIPLANAR IMAGING (Including computed tomography, ultrasound and magnetic resonance imaging of:)			
				• Chest			
				• Abdominal			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Head			
				• Neck			
				• Spine			
				• Musculoskeletal			
				5. NUCLEAR MEDICINE			
				• Planar imaging			
				• SPECT imaging			
				• Pharmaceutical enhanced imaging			
				CATEGORY II			
				6. NEURORADIOLOGY			
				• Myelography			
				• Angiography including aortic arch and major vessels			
				• Neuro Venography			
				• Therapeutic embolization			
				Intracranial/Spinal			
				Extracranial			
				• Cisternal puncture/C 1-2 puncture			

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M	E	H	R			Competency	Other
				• Interventional Spine procedure (including cysts and cord puncture			
				• Temporary balloon test occlusion			
				7. HEAD AND NECK			
				• Angiography of the Head & Neck			
				• Sialogram			
				• Dacrocystography			
				8. INTERVENTIONAL RADIOLOGY			
				• Percutaneous biopsy			
				• Percutaneous aspiration and/or drainage			
				• Injection or sclerosis of tumor, lesion or cavity			
				9. CARDIOVASCULAR INTERVENTIONAL			
				• General angiography			
				• Venography			
				• Interpretation of Cardiac catheterization, coronary angiography, left ventriculography			
				• Pulmonary angiography, right heart catheterization			
				• Transluminal angioplasty, fibrinolysis, atherectomy, stent replacement			
				• Embolotherapy and infusion therapy			

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				• Percutaneous placement venous access device			
				• Vena Cava filter placement			
				• Hepatobiliary intervention (transhepatic cholangiography, endoprosthesis, biliary stone removal.			
				• Lymphangiography			
				• Fallopian tube recanalization			
				• Transjugular intrahepatic portacaval stent shunt			
				10. ABDOMINAL			
				• Percutaneous transhepatic cholangiography			
				• Biliary stone removal			
				11. GENITO-URINARY			
				• Percutaneous pyelography			
				• Percutaneous nephrostomy			
				• Retrograde urethrogram			
				• Hysterosalpingogram			
				• Ureteral stent			
				12. MAMMOGRAPHY			

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REQUESTED				DESCRIPTION OF PRIVILEGE	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				• Screening Mammography			
				• Diagnostic Mammography			
				• Stereotactic Breast Localization and / or Biopsy			
				• Needle localization			
				• Ductogram			
				• Percutaneous aspiration and biopsy			
				13. MUSCULOSKELETAL			
				• Arthrography			
				14. NUCLEAR MEDICINE			
				• Radiotherapy with unsealed source			
				• Pet Imaging			
				15. MODERATE/DEEP SEDATION, requires competency exam.			
				16. OTHER			

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M	E	H	R			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

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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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