



Privileges in Radiology Service, Nuclear Medicine

Name: _____

Please Print

MEDICAL STAFF CATEGORY REQUESTED:

- Active** – Uses Stanford Hospital & Clinics (SHC) as a primary hospital and regularly admits/treats, consults, patients at this facility, or is regularly involved in medical staff functions. (Minimum 11 pt contacts per year)
- Courtesy-Admitting** – Member in good standing in another TJC, AAAHC or AAAASF accredited hospital, and admits/treats 3 – 10 patients per year at SHC
- Courtesy-Teaching** – Treats SHC patients only when incident to performing clinical teaching responsibilities. Must have teaching appointment with the Stanford School of Medicine

Please indicate any teaching title you may hold with the Stanford School of Medicine:

- Faculty (MCL, CE or UTL) Adjunct Clinical Faculty

Teaching Title: _____

REQUESTED	PROCEDURE	INITIAL CRITERIA	RENEWAL CRITERIA	PROCTORING REQUIREMENTS
CORE PRIVILEGES				
<input type="checkbox"/>	<p><u>Privileges included in the Core:</u> Privileges to make an assessment of a clinical history, supervise the preparation, administration, and use of unsealed radionuclides and radiopharmaceuticals for diagnostic examinations of patients.</p> <p><u>Cross out & INITIAL any privilege/s you are not applying for in this set of Basic Privileges</u></p> <p>Core privileges include:</p> <ul style="list-style-type: none"> Interpreting the results of diagnostic examinations of patients using unsealed radionuclides and radiopharmaceuticals Supervising the preparation, administration, and use of unsealed radionuclides and radiopharmaceuticals for therapeutic purposes Performing radioimmunoassay examinations and managing radioactively contaminated patients and facilities Internal therapy usually requiring hospitalization for purposes of radiation safety Use of sources in devices for diagnostic studies involving transmission of excitation Supervision of cardiac stress testing for Cardiac Nuclear Medicine procedures Fine needle aspiration biopsy of the thyroid Consultation and/or care of patients with diseases of thyroid Positron Emission Tomography (PET) 	<p>Successful completion of an ACGME or AOA-accredited residency/fellowship in nuclear medicine or foreign equivalent training.</p> <p style="text-align: center;"><u>AND Either</u></p> <p>Current certification or active participation in the examination process leading to certification in nuclear medicine by the American Board of Nuclear Medicine or the American Osteopathic Board of Nuclear Medicine or foreign equivalent training/board.</p> <p style="text-align: center;"><u>OR</u></p> <p>Documentation or attestation of recent performance of at least 100 nuclear medicine procedures at an accredited facility, during the past two years</p>	<p>Reappointments: please be prepared to provide a list of cases performed at facilities other than SHC if requested.</p> <p>_____ # of cases in the past 2 years</p> <p>Minimum of 100 cases required</p>	<p>General - 5 Exam Reviews</p>

SPECIAL PRIVILEGES (MUST ALSO MEET THE CRITERIA ABOVE)				
REQUESTED	PROCEDURE	ADDITIONAL CREDENTIALING CRITERIA	# of Cases performed in past 2 yrs **	Proctoring Requirements
<input type="checkbox"/>	Administration of Moderate Sedation	In accordance with Hospital Sedation Policy and completion of the SHC sedation exam	Sedation exam every 4 years	2 observations
<input type="checkbox"/>	Treatment of patients in outpatient clinics at Stanford Hospital & Clinics	Must have teaching appointment through the Stanford School of Medicine.		
<input type="checkbox"/>	Treat or provide follow-up care for inpatients ages 14 years or younger	Must have membership and privileges at Lucile Packard Children's Hospital		

**** On a separate sheet of paper, please describe any major, unexpected complications you have encountered for any of the Core Privileges or Additional Privileges you are requesting**

NOTE: PROCTORING IS REQUIRED FOR ALL INITIAL PRIVILEGES REQUESTED and MUST BE COMPLETED WITHIN 12 MONTHS

ACKNOWLEDGMENT 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 Stanford Hospital & Clinics. I also acknowledge that my professional malpractice insurance extends to all privilege I have requested.

I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature: _____ Date _____

If sending by email, type your name in the box above.
 If sending by mail, please print first and then sign.