DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date:

RADIOLOGY PRIVILEGES REQUEST FORM

INTRODUCTION

The Radiology Privileges Request Form must be accompanied or preceded by a complete application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of radiology are listed below. The request for privileges must reflect both the applicant's and the facility's/staff's ability to carry out or support the various functions. Documentation of training and/or experience in performing various procedures/modalities must accompany this request. Any additional privileges may be requested on the form or may be presented in an attached list.

INSTRUCTIONS FOR COMPLETING THE FORM

Applicant: With a check mark in the appropriate location, indicate for each item whether you are requesting either *limited* or *full* privileges. *Limited* means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding *full* privileges. *Full* means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on page 4.

Discipline-specific supervisor or consultant: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either *full, limited,* or *not recommended* (N.R.). Please explain any recommended limitations or denial of privileges on an attached sheet. This recommendation is considered by the governing body when granting or not granting privileges.

I. RADIOGRAPHIC EXAMINATIONS

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. General diagnostic roentgenology	☐	☐	☐	☐	☐
B. Barium studies, including small bowel enterolysis and air-contrast barium enemas	☐	☐	☐	☐	☐
C. Intravenous pyelography	☐	☐	☐	☐	☐
D. Fistula and sinus tract studies	☐	☐	☐	☐	☐
E. Myelography (cervical, lumbar, & thoracic)	☐	☐	☐	☐	☐
F. Other (specify): _____	☐	☐	☐	☐	☐

II. COMPUTERIZED TOMOGRAPHIC EXAMINATIONS

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Head (including temporal bone and pituitary)	☐	☐	☐	☐	☐
B. Neck (including salivary glands, and larynx)	☐	☐	☐	☐	☐
C. Chest	☐	☐	☐	☐	☐
D. Abdomen	☐	☐	☐	☐	☐
E. Pelvis	☐	☐	☐	☐	☐
F. Spine	☐	☐	☐	☐	☐
G. Extremities	☐	☐	☐	☐	☐
H. Other (specify): _____	☐	☐	☐	☐	☐

III. ULTRASOUND

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Aortic sonography	☐	☐	☐	☐	☐
B. Obstetrical sonography	☐	☐	☐	☐	☐
C. Biophysical profile	☐	☐	☐	☐	☐
D. Gallbladder sonography	☐	☐	☐	☐	☐
E. Liver sonography	☐	☐	☐	☐	☐
F. Pancreatic sonography	☐	☐	☐	☐	☐
G. Splenic sonography	☐	☐	☐	☐	☐
H. Pelvic sonography	☐	☐	☐	☐	☐
I. Renal sonography	☐	☐	☐	☐	☐
J. Thyroid sonography	☐	☐	☐	☐	☐
K. Vascular sonography	☐	☐	☐	☐	☐
1. Deep venous (abd/extrem, etc.)	☐	☐	☐	☐	☐
2. Carotid	☐	☐	☐	☐	☐
L. Sonography of soft tissue masses or fluid collections	☐	☐	☐	☐	☐
M. Sonography for thoracentesis guidance	☐	☐	☐	☐	☐
N. Sonography for guidance of other needle aspiration or biopsy	☐	☐	☐	☐	☐
O. Sonography for placement of indwelling catheters (nephrostomy, gall bladder)	☐	☐	☐	☐	☐
P. Other (specify): _____	☐	☐	☐	☐	☐

IV. MAMMOGRAPHY

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Mammogram interpretation	☐	☐	☐	☐	☐
B. Needle localization for biopsy	☐	☐	☐	☐	☐
C. Galactography	☐	☐	☐	☐	☐

V. SPECIAL PROCEDURES

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Abscess drainage	☐	☐	☐	☐	☐
B. Drainage of fluid collections	☐	☐	☐	☐	☐
C. Biopsy/fine needle aspirates	☐	☐	☐	☐	☐
D. Arthrography:	☐	☐	☐	☐	☐
1. Shoulder	☐	☐	☐	☐	☐

V. SPECIAL PROCEDURES

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
2. Wrist	☐	☐	☐	☐	☐
3. Knee	☐	☐	☐	☐	☐
E. Percutaneous gallstone removal	☐	☐	☐	☐	☐
F. Percutaneous nephrostomy tube placement	☐	☐	☐	☐	☐
G. Percutaneous biliary drainage tube placement	☐	☐	☐	☐	☐
H. Percutaneous transhepatic cholangiography	☐	☐	☐	☐	☐
I. Venography	☐	☐	☐	☐	☐
J. Other (specify): _____	☐	☐	☐	☐	☐

RADIOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

   _____ _____
   Applicant Date

2. I hereby recommend the clinical privileges as indicated.

   _____ _____
   Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (check one)

   ___ As noted.

   ___ With the following exceptions, deletions, additions, or conditions:

   _____

   _____ _____
   Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

   _____ _____
   Service Unit Director Date

5. Privileges are hereby granted: (check one)

   ___ As noted.

   ___ With the following exceptions, deletions, additions, or conditions:

   _____

   _____ _____
   Chairperson of the Governing Body Date

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.