DELINEATION OF CLINICAL PRIVILEGES - THERAPEUTIC RADIOLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Category 1. Includes practitioners who have completed a minimum of three years in an accredited Radiation Oncology program but are not board certified in Radiation Oncology. This includes practitioners who are board certified in Diagnostic Radiology, with special competency in Radiation Oncology, who also have had significant clinical experience practicing Radiation Oncology in the civilian setting (i.e., Diagnostic Radiologists who trained greater than 10 years ago and have "grandfathered" into the specialty.)

Requested	Approved	
		Category I clinical privileges

Category II. Includes practitioners who trained a minimum of 3 or 4 years in an accredited Radiation Oncology program and are actually engaged in the board certification process. This includes physicians who may have successfully completed full written boards and are awaiting their oral boards. It also includes prior category 3 practitioners who have not re-certified according to American Board of Radiology guidelines.

Requested	Approved	
		Category II clinical privileges

Category III. Includes practitioners who have specialty board certification by the American Board of Radiology or its equivalent. Practitioners who fail to re-certify per guidelines of the American Board of Radiology will revert to category 2 level of privileges.

Requested	Approved	
		Category III clinical privileges

Privileges

Requested	Approved		Requested	Approved	
		a. External Beam			d. Treatment with Radio-pharmaceuticals
		b. Brachy Therapy			(1) Strontium
		(1) Low dose rate (LDR)			(2) P-32
		(a) Intracavitary			(3) Other *(Specify)*
		(b) Interstitial			
		(2) High dose rate (HDR)			e. Intraoperative Radiation Therapy (IORT)
		(3) Coronary Artery Brachy Therapy			f. Other *(Specify)*
		(4) Prostate Brachy Therapy			
		c. Stereotactic Radiosurgery			

COMMENTS

COMMENTS *(Continued)*

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

EVALUATION OF CLINICAL PRIVILEGES - THERAPEUTIC RADIOLOGY

(For use of this form, see AR 40-68; the proponent agency is OTSG.)

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	PRIVILEGES			
	a. External Beam			
	b. Brachy Therapy			
	(1) Low dose rate (LDR)			
	(a) Intracavitary			
	(b) Interstitial			
	(2) High dose rate (HDR)			
	(3) Coronary Artery Brachy Therapy			
	(4) Prostate Brachy Therapy			
	c. Stereotactic Radiosurgery			
	d. Treatment with Radio-pharmaceuticals			
	(1) Strontium			
	(2) P-32			
	(3) Other *(Specify)*			
	e. Intraoperative Radiation Therapy (IORT)			
	f. Other *(Specify)*			

SECTION II - COMMENTS *(Explain any rating that is "Unacceptable".)*

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*