



**Delineation of Privileges
Department of Radiology
RADIOLOGY**

NAME: _____

MINIMUM QUALIFICATIONS FOR PRIVILEGES:		
<ul style="list-style-type: none"> Practitioners must be duly licensed to practice in the State of Florida and hold a valid DEA certificate. Successful completion of an ACGME or AOA-accredited residency/fellowship in radiology. Current certification or active participation in the examination process leading to certification in Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology. 		
CATEGORY I: CORE RADIOLOGY PRIVILEGES		
Core Radiology Privileges <i>include</i>:	Requested	Approved
1. General diagnostic radiographs, ultrasound, CT, nuclear medicine studies, and other general radiology procedures including, but not limited to IVPs, gastric and barium studies, and conscious sedation.		
CATEGORY II: MAGNETIC RESONANCE IMAGING		
Credentialing criteria: <ol style="list-style-type: none"> 1. Six months dedicated to MRI training during residency training; <u>OR</u> 2. Documentation of 300 hours dedicated to MRI continuing medical education, predominantly MRI fellowship, with 200 of these hours obtained in the past two years <u>AND</u> satisfactory completion of 100 cases of MRI overreads by Radiologist with approved MRI privileges. 	Requested	Approved
CATEGORY III: INTERVENTIONAL PROCEDURES - LOWER LEVEL		
Additional minimum requirements: Performance of at least 60 of the following procedures per year; annual review of complications.		
<ul style="list-style-type: none"> Vascular Interventional/Diagnostic: 	Requested	Approved
1. Non-invasive vascular assessment:		
➤ Ultrasound		
➤ Plethomography		
➤ Segmental pressures		
➤ Indices		
➤ Physical exam		
2. Basic Angiography/Arterial including but not limited to:		
➤ Aortagram		
➤ Cerebral Arteriogram		
➤ Renal Arteriogram		
➤ Mesenteric Arteriogram		
➤ Celiac Arteriogram		
➤ Extremity Arteriogram		
➤ Spinal and Bronchial Arteriogram		
3. Basic Angiography/Venous including but not limited to:		
➤ Shunts		
➤ Central Lines		
➤ Peripheral Veins		
➤ Pulmonary Vessels		
➤ Splenoportography		
<ul style="list-style-type: none"> Non-Vascular Interventional/Therapeutic: 		
1. Drainage:		
➤ Abscess		
➤ Pseudocysts		
➤ Pneumothorax		
➤ Pleuro and Thoracentesis		
➤ Urinomas		
➤ Lymphoceles		
➤ Hematomas		

NAME: _____

• Non-Vascular Interventional/Diagnostic:	Requested	Approved
1. Biopsy (by any method):		
➤ Soft Tissue:		
a. Breast		
b. Intraperitoneal		
c. Retroperitoneal		
d. SQ areas (all accessible locations)		
➤ Adrenal		
➤ Bone		
➤ Lung or Pleural Wall		
➤ Renal		
➤ Prostate		
➤ Liver		
➤ Spleen		
➤ Pancreas		
2. Drainage (by any method) :		
➤ Soft Tissue:		
b. Breast		
c. Intraperitoneal		
d. Retroperitoneal		
e. SQ areas (all accessible locations)		
➤ Bone		
➤ Lung or Pleural Space		
➤ Renal		
➤ Prostate		
➤ Liver (including biliary system and gallbladder)		
➤ Spleen		
➤ Pancreas		
3. Injections:		
➤ Arthrograms		
➤ Galactograms		
➤ Ocular ducts		
➤ Fistulas (all types)		
➤ Myelograms		
➤ Lymphograms		
➤ Salivary Glands		
4. Localization:		
➤ Breast lesions		
➤ Other lesions		
CATEGORY IV: INTERVENTIONAL PROCEDURES - UPPER LEVEL		
Additional minimum requirements:		
1. Completion of an approved fellowship in Interventional Radiology/Neuroradiology, 1 year full time, <u>OR</u>		
2. Certification by the American Board of Radiology in additional qualifications in Interventional Radiology/Neuroradiology; <u>OR</u>		
3. Documentation of performance of 100 interventional cases during one year performed within the past 3 years, <u>AND</u>		
a. Documentation of performance of 50 angiograms during one year performed within the past 3 years which must include at least 12 stents, 12 infusion therapies, and 5 other cases (embolic, biliary stent, nephrostomies, etc) performed in a one year period.		
• Vascular Interventional - Therapeutic Services:		
1. Embolic Procedures:	Requested	Approved
➤ Coils		
➤ Solid Materials (Gelfoam, auto-clot)		
➤ Direct mechanical (US)		
➤		

NAME: _____

• Vascular Interventional - Therapeutic Services:		Requested	Approved
2. Angioplasty:			
➤ Arterial			
➤ Venous			
3. Stenting:			
➤ Arterial			
➤ Coronary			
➤ Carotid			
➤ Iliac			
➤ Femoral			
➤ Renal			
➤ Venous			
4. Infusion Therapy/Thrombolytic:			
➤ Arterial			
➤ Venous			
a. Shunts			
b. DVT			
c. Pulmonary			
5. Infusion Therapy/Non-Thrombolytic:			
➤ Vasoconstrictors			
➤ Vasodilators			
➤ Embolic Solutions (ETOH)			
6. Filters (Venous)			
7. Vascular Pumps (Chemotherapy long term):			
➤ Port type			
➤ Permcath type			
➤ PICC type			
8. Vascular Access and/or Repositioning:			
➤ Port type (with pocket and tunnel)			
➤ Permcath type (with tunnel only)			
➤ PICC type (peripheral)			
➤ Pressure monitoring equipment			
• Non-Vascular Interventional/Therapeutic Services (including but not limited to):		Requested	Approved
1. Stenting/Angioplasty:			
➤ Biliary			
➤ Ureter			
➤ Pancreatic			
2. Tube Placement:			
➤ G-tubes			
➤ Chest tubes			
➤ Nephrostomy tubes			
➤ Biliary tubes			
3. Ablation Solutions:			
➤ Hepatic Cysts			
➤ Renal cysts			
4. Stone Removal:			
➤ Bile ducts			
➤ Kidney			
➤ Gallbladder			
• Other (provide documentation of training and experience):		Requested	Approved
1.			
2.			
3.			
4.			

I hereby certify that I possess the training, skill, experience, and current competency for the clinical privileges I have requested and pledge to practice within the limitations and scope of these privileges. Category II privileges cannot be requested or approved without requesting and approving Category I Core privileges.

Physician Signature

Date

APPROVAL:

Chief of Radiology

Date