

**BAYLOR SCOTT & WHITE TEXAS SPINE & JOINT HOSPITAL  
RADIOLOGY CLINICAL PRIVILEGES**

NAME: \_\_\_\_\_

- Initial appointment
- Reappointment

**Applicant:** Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

**Minimum Requirement:** 500 interpretations transcribed during two-year appointment period: onsite and verified via case logs

**QUALIFICATIONS FOR DIAGNOSTIC RADIOLOGY**

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*To be eligible to apply for core privileges in diagnostic radiology, the initial applicant must meet the following criteria:*

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in diagnostic radiology.

**CORE PRIVILEGES**

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**DIAGNOSTIC RADIOLOGY CORE PRIVILEGES**

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- Requested** Perform general diagnostic radiology to diagnose and treat diseases of patients of all ages. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

*This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.*

REQUESTED	PRIVILEGE	APPROVED	DENIED
	<b>Fluoroscopy</b>		
	<b>Interpretation of Diagnostic Radiographs</b>		
	<b>Ultrasound Procedures-Diagnostic</b> Abdominal Pelvic Cardiac (Echocardiography)		
	<b>Computed Tomography-Diagnostic</b> Neurological (Including Sprine) Thorax Abdomen & Pelvis, Skeletal & Extremities		

<b>REQUESTED</b>	<b>PRIVILEGE</b>	<b>APPROVED</b>	<b>DENIED</b>
	<b>Magnetic Resonance Imaging</b>		
	<b>Arthrography</b>		
	<b><u>Needle Biopsy-Percutaneous</u> CT Control Ultrasound Control Fluoroscopic Control</b>		
	<b><u>Neurological</u> Lumbar Puncture w/Fluoroscopy C1-2 Puncture with Fluoroscopy Myelography Discography</b>		
	<b><u>Hepatic</u> Percutaneous Needle Biopsy with CT or Ultrasound</b>		
	<b><u>Percutaneous Drainage of Abscess and Fluid Collections</u> Fluoroscopic Control Ultrasound Control CT Control</b>		
	<b>Mild Sedation (Required Current ACLS)</b>		
	<b><u>Line Placement</u> Central Mid-Line Picc</b>		

### **Acknowledgement of Practitioner**

I am qualified to perform the privileges I have requested based on my licensure, education, training, experience and current competence. I certify that I am able to perform the privileges I have requested.

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**Practitioner's Signature**

\_\_\_\_\_  
**Date**