SCOTLAND HELATH CARE SYSTEM
Clinical Privileges Delineation Form
Specialty: Radiation Oncology

In order to be eligible to request clinical privileges for Radiation Oncology, an applicant must meet the following minimum threshold criteria:

- **Education:** MD or DO
- **Minimum Formal Training:** The applicant must demonstrate successful completion of five years of ACGME approved training with a minimum of four years in radiation oncology.
- **Required Previous Experience:** The applicant must be able to demonstrate that he/she has provided radiation oncology treatment to at least 50 patients in the past 12 months.
- **References:** A letter verifying satisfactory completion of the applicant's radiation oncology training program from the Director of the training program, or a letter of reference must come from the Department Chair at the institutions where the applicant previously practiced.

RADIATION ONCOLOGY CORE PRIVILEGES:

Core privileges in Radiation Oncology include *being able to admit, work up, diagnose and provide treatment or consultative services to patients of all ages presenting with malignant tumors.*
Additional Medical Oncology Core Privileges include the following:

- Bone Marrow Aspiration & Biopsy
- Administration of Chemotherapeutic Agents and Biological Response Modifiers through all therapeutic routes
- Management & maintenance of indwelling venous access catheters

- **Reappointment:** Reappointment will be based on unbiased, objective results of care according to Scotland Memorial Hospital's existing performance improvement mechanisms.

Applicants must be able to demonstrate that they have maintained competence by showing evidence that they have provided medical oncology treatment to at least 100 patients in the last 24 months.

In addition, continuing education related to Oncology will be required.

Special Requests: Competence must be demonstrated:

Procedure	Requested
	❑
	❑
	❑
	❑
	❑
	❑
	❑

I understand that by making this request I am bound by the applicable bylaws or policies of the hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

Physician Signature: _____

Date: _____