



University of Michigan  
Hospitals and Health Centers

UNIVERSITY OF MICHIGAN HOSPITALS AND HEALTH CENTERS

Delineation of Privileges  
Department of Radiation Oncology

Name: \_\_\_\_\_  
Please Print or Type

LEVEL I CORE PRIVILEGES

Minimum Training and Experience

All new and current faculty must provide proof of:

1. MD, or DO, or equivalent international medical degree, and
2. Successful completion of a postgraduate residency program in Radiation Oncology and/or Radiology approved by the Accreditation Council for Graduate Medical Education or its equivalent, and
3. Must successfully complete examination for American Board of Radiology in Radiation Oncology or Therapeutic Radiology within 3 years of completion of residency or fellowship.

New faculty must provide:

1. Two letters of reference from colleagues aware of applicant's clinical ability to perform Level 1 activities,  
- or -
2. A letter of satisfactory completion from the Director of the Fellowship or Residency Program, if the request for privileges immediately follows a Fellowship or Residency. The Director's letter must comment specifically upon the applicant's clinical ability.

Current faculty must provide:

Continued experience in radiation oncology as documented by treatment of at least 20 patients in the previous privileging period. Documentation by submission of dictated treatment summaries is satisfactory.

**Scope of Practice/Privileges** Clinical care of the patient who may be a candidate for or has been treated with radiation therapy. Privileges also include limited biopsy procedures such as fine needle aspiration.

**FPPE Requirements (New Hire or Add Privileges):** Outpatient monitoring activity: 3 cases/month for 6 months. Monitor will schedule one 1hr meeting per month to review cases and discuss upcoming clinics (i.e., conduct prospective and retrospective review at same meeting).

Requested (Applicant)       Recommended approval (Service Chief/Chair)

**Scope of Practice/Privileges** Therapeutic application of radiant energy (electromagnetic or particulate) generated by high voltage equipment or emanating from naturally occurring and artificially produced radioactive substances. Such treatment is used primarily in the management of malignancy but also, if appropriate, in benign tumors and , in rare instances, non-neoplastic diseases. Privileges also include treatment planning, delivery of external beam irradiation, and brachytherapy.

**FPPE Requirements (New Hire or Add Privileges):** Outpatient monitoring activity: 3 cases/month for 6 months. Monitor will schedule one 1hr meeting per month to review cases and discuss upcoming clinics (i.e., conduct prospective and retrospective review at same meeting).

**Privileges also include the following representative list, but it is not intended to be all-encompassing, but rather to reflect the categories/types of patient problems included in the description of privileges.**

- 3-D conformal therapy
- Admit, evaluate, diagnose, consult, manage and treat, on an in-patient/out-patient basis, patients of all ages needing radiation therapy.
- Combined modality therapy
- Computerized treatment planning
- Conventional simulator with fluoroscopy
- CT/MR simulation
- Drugs and medicines related to radiation oncology/cancer support care, administration of
- External beam radiotherapy with orthovoltage or megavoltage equipment employing photons or electrons
- Fine needle aspiration/biopsy
- Half-body radiation
- Hyperfractionation
- Hypofractionation
- IGRT
- IMRT
- Large field radiation techniques
- Nutritional counseling
- Particle therapy
- Plaque therapy
- Radioactive implants for prostate, gynecologic, brain tumors, and other appropriate sites
- Radioimmunotherapy
- Radionuclide therapy, unsealed
- Yttrium microspheres
- Radiosurgery
- Superficial irradiation

**Requested (Applicant)**

**Recommended approval (Service Chief/Chair)**

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## **LEVEL II**

### **Minimum Training and Experience**

#### **All new and current faculty must provide proof of:**

1. Meeting Level I training and experience  
and
2. One of the following:
  - a. Documentation of successful completion of a post residency training course that specifically addresses the requested privilege (i.e., certified completion of a recognized hyperthermia course), or
  - b. Completed an approved residency program that includes the requested activity (letter from Residency Director required specifically indicating clinical competence in each of the requested Level II privileges), or
  - c. Has documented experience in the procedure with 5 or more cases without adverse events (to be confirmed by Department Chair or designee)

#### **Current faculty must provide:**

1. Attestation of active clinical status - treating at least one case with the Level II modality - in the previous privileging period, and
2. Maintenance of any recertification requirements, if such exist, as defined by the American Board of Radiology.

### **Scope of Practice/Privileges**

#### *Special Procedures:*

These privileges require specialty training and are not considered part of standard core privileges.

**FPPE Requirements (New Hire or Add Privileges): Outpatient monitoring activity: 1 case/month for 6 months. Monitor will schedule one 1hr meeting per month to review cases and discuss upcoming clinics (i.e., conduct prospective and retrospective review at same meeting).**

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### HDR Brachytherapy

Requested (Applicant)                       Recommended approval (Service Chief/Chair)

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#### **SPECIAL PRIVILEGES**

**A separate application is required to APPLY or REAPPLY for the following Special Privileges:**

- ▶ **LASER**
- ▶ **ROBOTIC SURGICAL PLATFORM**
- ▶ **SEDATION PRIVILEGES FOR A NON-ANESTHESIOLOGIST**

**PLEASE go to URL: [www.med.umich.edu/i/oca](http://www.med.umich.edu/i/oca) for instructions, or contact your Clinical Department Representative.**

#### **TO BE COMPLETED BY APPLICANT:**

I meet the previously stated minimum criteria and request that my application be considered for the privileges as outlined above. I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the Medical Staff of The University of Michigan Health System.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **DEPARTMENT ACTION:**

##### **Approval:**

\_\_\_\_\_ As Requested                      \_\_\_\_\_ As Modified  
(please explain)

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Justification for approval is based on careful review of the applicant's education, postgraduate clinical training, demonstrated clinical proficiency and Board Certification or qualifications to sit for the Boards.

Department Chair: \_\_\_\_\_ Date: \_\_\_\_\_ Service Chief: \_\_\_\_\_ Date: \_\_\_\_\_

#### **CREDENTIALS COMMITTEE ACTION:**

\_\_\_\_\_ Approval as Requested                      \_\_\_\_\_ Not Approved  
(please explain)

Credentials Committee Member: \_\_\_\_\_ Date: \_\_\_\_\_

#### **EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS ACTION:**

\_\_\_\_\_ Approval as Requested                      \_\_\_\_\_ Not Approved  
(please explain)

Executive Committee On Clinical Affairs - Member: \_\_\_\_\_ Date: \_\_\_\_\_