DELINEATION OF CLINICAL PRIVILEGES - NUCLEAR MEDICINE

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	SUPERVISOR 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/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Category I.

Includes practitioners who have completed a limited training program in nuclear medicine, such as part of an accredited residency. Under this category of privileges, practitioners may perform and interpret procedures only within a specialized area of nuclear medicine (e.g. heart, thyroid).

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.

Includes practitioners who have completed a minimum of six months of nuclear medicine training, involving all organ systems, in an accredited program, but are not necessarily board certified. Under this category practitioners may perform and interpret in multiple areas but must request consultation to perform or interpret modified or new procedures, or when the diagnosis is in doubt.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.

Includes practitioners who have completed eighteen months of nuclear medicine training in an accredited program, but who are not necessarily board certified. Under this category practitioners may perform and interpret in multiple areas but must request consultation when the diagnosis is in doubt.

Requested	Approved	
		Category III clinical privileges

Category IV. Includes Categories I, II and III.

Includes practitioners who have specialty certification granted by the American Board of Nuclear Medicine, the American Board of Radiology with Special Competence, or their equivalent. Members in this category may perform and/or interpret procedures on a full-time basis without consultation.

Requested	Approved	
		Category IV clinical privileges

DIAGNOSTIC NUCLEAR MEDICINE

a. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. All organ systems. *(Specify imaging systems below.)*

b. In-vivo imaging and non-imaging evaluations using radiopharmaceuticals. Limited to *(Specify organ systems):* _____ *(Specify imaging systems below.)*

Requested	Approved		Requested	Approved	
		(1) planar			(1) planar
		(2) SPECT			(2) SPECT
		(3) PET (coincidence or dedicated)			(3) PET (coincidence or dedicated)

THERAPEUTIC NUCLEAR MEDICINE

Requested	Approved	
		a. Treatment of patients using radiopharmaceuticals. All radioisotopes.
		b. Treatment of patients using radiopharmaceuticals that is limited to (Specify radioisotopes and/or procedures, e.g., I-131 for hyperthyroidism):

IN-VITRO NUCLEAR MEDICINE		
Requested	Approved	
		a. Laboratory type studies including radioimmunoassay and blood volume/component analysis using radiopharmaceuticals. All procedures.
		b. Laboratory type studies including radioimmunoassay and blood volume/component analysis using radiopharmaceuticals that is limited to (*Specify procedures):*

ADDITIONAL PRIVILEGES					
Requested	Approved		Requested	Approved	
		a. Bone Densitometry			

COMMENTS

	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/FUNCTION RECOMMENDATION

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

COMMENTS

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