EVALUATION OF CLINICAL PRIVILEGES - THERAPEUTIC RADIOLOGY

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. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	PRIVILEGES			
	a. External Beam			
	b. Brachy Therapy			
	(1) Low dose rate (LDR)			
	(a) Intracavitary			
	(b) Interstitial			
	(2) High dose rate (HDR)			
	(3) Coronary Artery Brachy Therapy			
	(4) Prostate Brachy Therapy			
	c. Stereotactic Radiosurgery			
	d. Treatment with Radio-pharmaceuticals			
	(1) Strontium			
	(2) P-32			
	(3) Other *(Specify)*			
	e. Intraoperative Radiation Therapy (IORT)			
	f. Other *(Specify)*			

SECTION II - COMMENTS ***(Explain any rating that is "Unacceptable".)***

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*