

THE NEW YORK EYE AND EAR INFIRMARY

DEPARTMENT OF RADIOLOGY

DELINEATION OF PRIVILEGES

NAME _____ DATE _____
(Please Print)

Instruction:

Applicant: Please initial beside each privilege you are requesting.

Chairman/Director: Please put a check (✓) in the appropriate column

	<u>Applicant</u> Privilege Requested	<u>Director of Service</u> Privilege Approved Privilege Denied	
I. <u>Radiology</u>			
Diagnostic Radiology	_____	_____
Computerized Tomography	_____	_____
Magnetic Resonance Imaging	_____	_____
Neuroradiology	_____	_____
II. <u>Special Procedures</u>			
Dacryocystography	_____	_____
Sialography	_____	_____
Lumbar Puncture with and without Intrathecal Contrast Administration	_____	_____
Biopsy (X-ray/CT Guidance)		_____	_____
III. <u>Radiation Oncology</u>			
Brachytherapy Pd-103	_____	_____
Brachytherapy I-125	_____	_____

SIGNATURE: _____ DATE: _____

APPROVED: _____ DATE: _____
Roy Holliday, M.D., Director of Radiology