Contra Costa Regional Medical Center
Privileges Request Form

Practitioner Name: _____

Departments (s)	Number	Privilege Descriptions D= With Direct Supervision C= With Consultation U= Unrestricted	D/C/U	Training/ Education	Experience	Current Competence	Requested	Granted	D= Denied P= Pending CNM=Criteria Not Met
		Teleradiology							
DIA **TEL**	**TDIA 1**	Plain Film Reading Fluoroscopy, GI, GU	U	DIA	N/A	12 months in last 4 years			
DIA **TEL**	**TDIA 2**	Ultrasonography	U	DIA	N/A	12 months in last 4 years			
DIA **TEL**	**TDIA 3**	Computed Tomography	U	DIA	N/A	12 months in last 4 years			
DIA **TEL**	**TDIA 6**	MRI and MRA	U	DIA	N/A	12 months in last 4 years			
DIA **TEL**	**TDIA 7**	Arthrography (Read-only)	U	DIA	5	2 cases in last 4 years			

_____ _____

Signature of Requesting Practitioner Date

_____ _____

Signature of Department Chairperson Date

*** Separate proctoring required**