Union West Surgery Center
PRIVILEGE REQUEST: RADIOLOGY

I would like to be granted privileges to perform the following procedures as indicated by a checkmark:

M.D. _____ Specialty: _____

REQ.	APP.	
_____	_____	Consulting
_____	_____	Interpretation of x-rays

_____ _____

Applicant Signature Date

Medical Executive Committee - Approved By:	Approval Date:
Board of Managers - Approved By:	Approval Date: