

Loma Linda University Behavioral Medicine Center

**Psychiatry Department
Psychiatry Privilege Request Form**

Membership Category: Provisional Active Consultant Courtesy

NAME: _____

CATEGORY	QUALIFICATIONS
All	Current demonstrated competence and an adequate volume of current experience with acceptable results for patients of all age groups, except as specifically excluded from practice. Successful completion of an ACGME accredited residency program in Psychiatry and board certified or eligible for certification examination by the American Board of Psychiatry and Neurology.
Coverage privileges only	Successful completion of residency in Psychiatry.
Child Psychiatry (3-13 yrs.)	Successful completion of two (2) years of specialized training in child psychiatry or in an accredited child psychiatric program; or Documentation of two (2) years work experience specific to the care and treatment of children.
Adolescent Psychiatry (14-17 yrs.)	Documentation of one (1) year work experience specifically related to the care and treatment of adolescents/adults.
Privileges Requiring Specialized Training and/or Experience are followed by an asterisk * Electroconvulsive Therapy (ECT)	Professional experience documented through CME activities (supply specific documentation); and/or Successful completion of an approved, recognized course when such exists, or acceptable supervised training and demonstration of indications for the procedure/test/therapy. <u>Biofeedback</u> Current certification from the Biofeedback Certification Institute of America or current proctoring by BCIA certified therapist (this status can be used for a maximum of 2 years) <u>Electroconvulsive Therapy (ECT)</u> Requires membership and ECT privileges at Loma Linda University Medical Center.

Applicant Name: _____

REQUESTED		CODE	PRIVILEGE	ACTION		
YES	NO			Approved	Condition s	Comment
GENERAL						
			Admitting privileges			
			Consulting privileges only			
			Prescribing controlled substances according to DEA			
			Supervision of Students and Residents			
			Supervision of Allied Health Professionals in the following circumstances: AHP is granted practice privileges by the Medical Staff. AHP operates under standardized procedures. AHP operates under other circumstances as recommended by the Medical Staff.			
			COVERAGE PRIVILEGES ONLY (Includes All Age Groups)			
CHILD PSYCHIATRY (3-13 years)						
			Management of <u>In-patients</u> ages 3 to 13, including Psychiatric assessment and physical examination.			
			Management of <u>Out-patients</u> ages of 3 to 13, including Psychiatric assessment and physical examination.			
			Therapy, which includes Individual, Family, Group, Psychopharmacological, and Chemical Dependency.			
			Biofeedback*			
ADOLESCENT PSYCHIATRY (14-17 Years)						
			Management of <u>In-patients</u> ages 14 to 17, including Psychiatric assessment and physical examination.			
			Management of <u>Out-patients</u> ages 14 to 17, including Psychiatric assessment and physical examination.			
			Therapy, which includes Individual, Family, Group, Psychopharmacological, and Chemical Dependency.			
			Biofeedback*			
ADULT & GERIATRIC PSYCHIATRY						
			Management of <u>In-patients</u> ages 18 and older, including Psychiatric assessment and physical examination.			
			Management of <u>Out-patients</u> ages 18 and older, including Psychiatric assessment and physical examination.			
			Therapy, which includes Individual, Family, Group, Psychopharmacological, and Chemical Dependency.			
			Biofeedback*			

Applicant Name: _____

Acknowledgment of Practitioner

I have requested only those specific privileges which by education, training, current experience and demonstrated performance I am qualified to perform, and for which I wish to exercise at Loma Linda University Behavioral Medicine Center, Inc. I also understand the following:

- (a) In exercising any clinical privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- (b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

Signed: _____

Date _____

Conditions/Modifications:

The requested clinical privileges have been approved by the Governing Body with the following conditions/modifications:

Code	Privilege	Condition/Modification	Explanation/Comment

RECOMMENDED:

Medical Director

Date

Chief of Service

Date

Credentials Committee

Date

Medical Staff Executive Committee

Date

APPROVED:

Governing Body Officer

Date