

Loma Linda University Medical Center
Allied Health Professional
Clinical Psychologist Privilege Request

Practitioner Name: _____

Practice Specialty Requested: _____ License # _____

REQUESTED		PRACTICE PRIVILEGE REQUESTED	ACTION		
YES	NO		Approved	Conditions	Defer
GENERAL PRIVILEGES					
		Write requests for tests, therapy, consults, transfers, and discharges			
		Consults in area of competence			
DISCIPLINE SPECIFIC PRIVILEGES					
		Mental retardation			
		Organic Brain Syndrome			
		Psychoses			
		Neuroses			
		Personality Disorders			
		Psychophysiologic Disorders			
		Special Symptoms			
		Transient Situational Disturbances			
		Behavioral Disorders of Childhood and Adolescence			
		Diagnostic Psychological Testing			
		Psychoanalytic Psychotherapy			
		Behavioral Therapy			
		Gestalt Therapy			
		Group Therapy			
		Crisis Evaluation and Therapy			
		Conjoint Therapy			
		Marital Therapy			
		Sex Therapy			
		Family Therapy			
		Geriatric Therapy (65+ years age)			
		Adolescent Therapy (14-18 years age)			
		Play Therapy			
		Biofeedback			

Acknowledgment of AHP

In accordance with the provisions of Section 3055 of the Business and Professions Code, I am licensed as a Clinical Psychologist in the State of California and subject to the Laws and the rules and regulations of the California licensing agency. I acknowledge that I have received a copy of the Medical Staff Bylaws and Rules and Regulations, and agree to be bound by the terms of the Bylaws and Policies of the Medical Staff and of the hospital and all other manuals and policies relevant to practice privileges at Loma Linda University Medical Center under the AHP category.

I have requested only those specific practice privileges for which by education, training, current experience and demonstrated performance for which I am qualified and wish to exercise at Loma Linda University Medical Center, Inc.; **and**

I understand that in exercising any practice privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant Signature

Date

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Clinical Psychologist Practice Privilege Form
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Applicant Name _____

Practice Specialty _____

Supervising Physician Signature

Date

Discipline Director

Date

Service Chief Signature

Date

Credentials Committee Chair

Date

Medical Staff Executive Committee Chair

Date

Governing Board Officer/Designee

Date