

Loma Linda University Behavioral Medicine Center
Loma Linda, CA 92354

PRIVILEGE FORM

CLINICAL AREA: LICENSED CLINICAL SOCIAL WORKER

Page 1 of 2

Name: _____

CATEGORY	QUALIFICATIONS
All	1. Masters Degree in Social Work from an accredited graduate school of Social Work. 2. Current California State LCSW license issued by the Behavioral Science-Examiners. 3. Meets Bylaw requirements for Allied Health Professionals. 4. Proctoring of 100% of patients - up to three (3) within the provisional privilege period.
Individual Psychotherapy	Documented training and/or supervised experience in the theory and practice of individual therapy/counseling.
Group Psychotherapy	Documented training and/or supervised experience in theory and practice of group therapy.
Family/Couple Psychotherapy	Documented training and/or supervised experience in the theory and practice of family/couple/marital therapy.
Chemical Dependency Counseling	Documented graduate course work in theory/techniques of chemical dependency counseling, inpatient hospital experience or documented concurrent work experience in a chemical dependency program.
Biofeedback	Certification and/or documented training and experience in a specialty area.

PRIVILEGE		ACTION		
Requested		Approved	Conditions	Comment
	NO			
	Individual psychotherapy			
	Adult			
	Adolescent			
	Child			
	Group Psychotherapy			
	Adult			
	Adolescent			
	Child			
	Family/Couple Psychotherapy			
	Chemical Dependency Counseling			
	Biofeedback			

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Acknowledgment of Practitioner

I have requested only those specific privileges for 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; **and**

I understand that:

- (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: _____

**** For Hospital and/or Clinic Use Only ****

Conditions/Modifications:

The requested clinical privileges have been approved by the Governing Body with the following conditions, modifications and the explanation for same.

Code	Privilege	Condition/Modification	Explanation/Comment

 Discipline Director

 Date

 Supervising Physician

 Date

 Credentials Committee

 Date

 Medical Staff Executive Committee

 Date

APPROVED:

 Governing Body Officer

 Date