FLOYD MEDICAL CENTER

Medical Staff Privilege Checklist

DEPARTMENT OF PSYCHIATRY

I, _____, M.D., D.O., do hereby apply for the following privileges in the Department of Psychiatry.

Please check all privileges desired. All privileges are first approved by the Department of Psychiatry and the Executive Committee. Final approval is granted by the governing board.

Fill in all blanks on the privileges checklist. For privileges <u>not requested, enter</u> ∅ or N/R.

PRIVILEGE	Requested	Approved
<u>CLASS I</u>		
Counseling of individual, marital and family groups	[ ]	[ ]
Counseling of individuals with problems related to drug and alcohol abuse	[ ]	[ ]
Vocational and career counseling	[ ]	[ ]
Community agency consultation	[ ]	[ ]
Basic skills of clinical diagnosis	[ ]	[ ]
Basic expertise in the diagnosis and treatment of the following who have psychiatric disorders:		
Adults 20+ yrs ___	[ ]	[ ]
Adolescents 13-19 yrs___	[ ]	[ ]
Children 6-12 yrs ___	[ ]	[ ]
Diagnosis and treatment of neurological disorders relevant to psychiatric practice	[ ]	[ ]
Diagnosis and treatment of psychophysiologic disorders	[ ]	[ ]
<u>CLASS II</u>		
Hospital Emergency Psychiatry	[ ]	[ ]
Legal aspects of psychiatry	[ ]	[ ]
Competency evaluations	[ ]	[ ]
Use of generally accepted techniques for diagnostic psychological assessment	[ ]	[ ]
Diagnosis, treatment, and management including detoxification of patients with alcoholism and drug abuse	[ ]	[ ]

PRIVILEGE	Requested	Approved
CLASS III		
Individual psychotherapy including long-term psychotherapy	[ ]	[ ]
Supportive psychotherapy	[ ]	[ ]
Brief psychotherapies	[ ]	[ ]
Crisis intervention	[ ]	[ ]
Family therapy	[ ]	[ ]
Marital therapy	[ ]	[ ]
Group therapy	[ ]	[ ]
Pharmacological therapies, short-term and long-term	[ ]	[ ]
Amytal interview	[ ]	[ ]
Behavior therapy	[ ]	[ ]
Sexual dysfunctions	[ ]	[ ]
CLASS IV		
Electroconvulsive therapy (anesthesia to be administered by an anesthesiologist)	[ ]	[ ]
OTHER:		
Telemedicine Consultation	[ ]	[ ]

(Please also check the privileges you will be consulting on via telemedicine)

Additions/Deletions/Conditions/Other Limitations:

_____

_____

Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform, and that I wish to exercise at Floyd Medical Center, and I understand that:

1. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.
3. All members of the medical staff are required to treat patients, their families, hospital staff, and colleagues in a respectful and professional manner at all times. Each member of the medical staff is expected to comply with hospital and medical staff code of conduct policies. Failure to do so may be the basis for dismissal.

Applicant Signature _____ Date: _____

APPROVED:

_____ _____
Department Chairman **Date**

EXECUTIVE COMMITTEE RECOMMENDATION

□ Concur with Department's recommendation and forward to governing body
□ Return to Department for clarification of the following:

_____

_____
Date

GOVERNING BODY APPROVAL

□ Yes
□ No

_____
Date