

# POLK MEDICAL CENTER

## Medical Staff Privilege Checklist

### DEPARTMENT OF PSYCHIATRY

I, \_\_\_\_\_, M.D., D.O., do hereby apply for the following privileges in Psychiatry.

Please indicate the privileges you are requesting by placing an (X) in the appropriate space. All privileges are first approved by the Medical Executive Committee. Final approval is granted by the governing board.

**Fill in all blanks on the privileges checklist. For privileges not requested, enter  $\emptyset$  or N/R.**

PRIVILEGE	Requested	Approved
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1	2	3

Class I

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 adults, adolescents, and children who have psychiatric disorders	[ ]	[ ]
Diagnosis and treatment of neurological disorders relevant to psychiatric practice	[ ]	[ ]
Diagnosis and treatment of psychophysiological disorders	[ ]	[ ]

1	2	3

Class II

Hospital Emergency Psychiatry	[ ]	[ ]
Legal aspects of psychiatry	[ ]	[ ]
Competency evaluations	[ ]	[ ]

PRIVILEGE	Requested	Approved
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Use of generally accepted techniques for diagnostic psychological assessment	[ ]	[ ]
Diagnosis, treatment, and management including detoxification of patients with alcoholism and drug abuse	[ ]	[ ]

			Class III
1	2	3	

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	[ ]	[ ]

Additions/Deletions/Conditions/Other Limitations:

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**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 Polk 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.

\_\_\_\_\_  
Requesting Physician's Signature

\_\_\_\_\_  
Date

APPROVED:

\_\_\_\_\_  
Credentials Committee Chairman

\_\_\_\_\_  
Date

**MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION**

\_\_\_\_\_ Concur with Credential Committee's recommendation and forward to governing body

\_\_\_\_\_ Return to Credentials Committee for clarification of the following:

\_\_\_\_\_  
Date

**BOARD APPROVAL** \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Date

06282018