



# Atrium Health

## IMPORTANT

Dear Applicant

Enclosed you will find the Delineation of Privileges Form specific to your specialty. This form reflects the minimum qualifications as outlined and approved by the Atrium Health Medical Staff.

- Please thoroughly review and select your desired clinical privileges. Check the box corresponding to the privileges that you are requesting. Applicants should only request those privileges where the criteria has been achieved.
- After you have selected your privileges, sign, date, and submit the **required documentation** for each privilege selected. (i.e. case logs, fellowship director letter, ACLS documentation)
- Where case logs are required, please include 1) Date of procedure, 2) Medical Record Number, 3) Procedure Type and 4) Privilege Number listed on the Delineation of Privileges Form.
- Privileges for which you have not selected or do not meet the minimum criteria cannot be performed.
- If you wish to perform privileges and do not have documentation of the minimum criteria requirements as outlined on the Delineation of Privileges Form, you will need to request permission to proctor through Medical Staff Services.
- Failure to return the Delineation of Privileges Form along with the required documentation will **delay** your start date.

If you have any questions or concerns, please contact the Medical Staff Services teammate assigned to your file.

**ATRIUM HEALTH  
DELINEATION OF PRIVILEGES  
SPECIALTY OF PSYCHIATRY**

Print Name \_\_\_\_\_

	YES		NO**	I have participated in direct patient care within the past two (2) years.
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**\*\*If the answer is No, please do not complete this form. Contact the Medical Staff Office at (704) 355-2147 for additional instructions regarding the required proctoring process.**

**If you would like to request Moderate Sedation (Conscious Sedation), please see the Moderate Sedation Delineation of Privileges form.**

**Initial appointment**     **Reappointment**     **Updated DOP**     **Request for Clinical Privileges**

**To be eligible for core privileges in General Psychiatry, the applicant must meet the following qualifications:**

- If the applicant is not currently certified in Psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) the applicant must:
  1. Provide documentation of successful completion of an ACGME or an AOA accredited psychiatry residency or fellowship training program, within the past five (5) years; **AND**
  2. Provide verification from the residency or fellowship program director that the Applicant successfully completed the program. Experience must include evidence of current clinical competence during the past two (2) years. The applicant has the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.
  
- If the applicant is currently certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), the applicant must:
  1. Provide documentation of inpatient, outpatient or consultative services for at least sixty (60) patients during the past two (2) years.

\_\_\_\_\_  
Print Name

**To be eligible for core privileges in Child and Adolescent Psychiatry, the applicant must meet the following qualifications:**

- If the applicant is not currently certified in Child and Adolescent Psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Board of Neurology and Psychiatry the applicant must:
  1. Provide documentation of successful completion of an ACGME or AOA accredited child and adolescent psychiatry fellowship program within the past five (5) years; **AND**
  2. Provide verification from the residency program director that the Applicant successfully completed the program. Experience must include evidence of current clinical competence during the past two (2) years. The applicant has the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.
- If the applicant is currently certified in child and adolescent psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Board of Neurology and Psychiatry, the applicant must:
  1. Provide documentation of inpatient, outpatient, or consultative services for at least sixty (60) patients during the past two (2) years;

NOTE 1: Physicians must apply for "CORE" privileges CPSY-1 in order to be eligible for clinical privileges in any of the complex subspecialty areas of Psychiatry listed below at any facility within Atrium Health.

NOTE 2: "CORE" privileges cannot be amended or altered in any way.

NOTE 3: \* **Special privileges (see qualifications and/or specific criteria) - PROVIDE THE NUMBER OF PROCEDURES PERFORMED WITHIN THE PAST TWO YEARS AND FACILITY WHERE THE PROCEDURES WERE PERFORMED.**

Print Name \_\_\_\_\_

CMC	PINEVILLE	UNIVERSITY CITY	CR	LINCOLN	CABARRUS	UNION	STANLY	ANSON	Cleveland	<b>GENERAL PSYCHIATRY CORE PRIVILEGES</b>	
			N/A							CPSY-1	Evaluation, diagnosis, admission, treatment, and consultation to patients of all ages presenting with mental, behavioral, addictive or emotional disorders, e.g., chemical dependency, psychoses, depression, anxiety disorders, substance use disorders, developmental disabilities, sexual dysfunctions, and adjustment disorders. Privileges include provision of consultations to physicians in other fields regarding mental, behavioral, addictive, or emotional disorders; the performance of histories, physical examinations, and mental status examinations, the ordering of laboratory and other diagnostic tests, and as needed the prescribing of non-psychotropic medications. Privileges include psychiatric pharmacotherapy; psychotherapy; family psychotherapy, hypnotherapy; behavior therapy; consultation to the courts; and the assessment, stabilization, and disposition determination of patients with emergency conditions and perform an in person face-to-face evaluation for restraint use for violent or self-destructive behavior.

**Reappointment Criteria for Continued Privileges (CPSY-1):**

The Physician must perform a minimum of fifteen (15) representative samples of General Psychiatry Core procedures over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for General Psychiatry Core privileges. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold any General Psychiatry Core (CPSY-1) but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLV	PSY-1	<b>PSYCHIATRY SPECIAL PRIVILEGES</b> Must apply for and maintain General Psychiatry Core Privileges (CPSY-1)	Number Performed Within The Past 2 Years	Location
	N/A		N/A	N/A	N/A			N/A		CPSY-1(a)*	Electroconvulsive Therapy (ECT)		
			N/A	N/A	N/A			N/A		CPSY-1(b)*	Drug Assisted Interview Techniques		
			N/A	N/A	N/A			N/A		CPSY-1(c)*	Transcranial Magnetic Stimulation (TMS)		

Print Name \_\_\_\_\_

CMC	PINEVILLE	UNIVERSITY CITY	CR	LINCOLN	CABARRUS	UNION	STANLY	ANSON	Cleveland	<b>CORE PSYCHIATRY PRIVILEGES – REHABILITATION HOSPITAL SETTING ONLY</b>	
N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	CPSY-4	Privileges include evaluation and management, as well as procedures approved for performance within the acute rehabilitation setting, in conjunction with the comprehensive rehabilitation treatment plan.

CMC	PINEVILLE	UNIVERSITY CITY	CR	LINCOLN	CABARRUS	UNION	STANLY	ANSON	Cleveland	<b>CHILD AND ADOLESCENT PSYCHIATRY CORE PRIVILEGES</b>	
			N/A							CPSY-2	Expert evaluation, diagnosis, admission, treatment, and consultation to children and adolescents presenting with mental, behavioral, addictive or emotional disorders, e.g., psychoses, depression, anxiety disorders, substance use disorders, developmental disabilities, sexual dysfunctions, and adjustment disorders. Privileges include provision of consultations to physicians in other fields and to general psychiatrists, regarding mental, behavioral, addictive, or emotional disorders in children and adolescents; the performance of histories, physical examinations, and mental status examinations, the ordering of laboratory and other diagnostic tests, and as needed the prescribing of non-psychotropic medications for children and adolescents.

**Reappointment Criteria for Continued Privileges (CPSY-2):**

The Physician must perform a minimum of fifteen (15) representative samples of Child and Adolescent Psychiatry Core procedures over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for Child and Adolescent Psychiatry Core privileges. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold any Child and Adolescent Psychiatry Core (CPSY-2) but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

Print Name \_\_\_\_\_

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLE		Must apply for and maintain Adult or Child and Adolescent Psychiatry Core Privileges (CPSY-1 or CPSY-2)	Number Performed Within The Past 2 Years	Location
		N/A	N/A	N/A	N/A					CPSY-3*	Medical Acupuncture		

\*Applicant must provide documentation from their training program of at least 200 hours of AMA Category I training in Medical Acupuncture, deemed satisfactory by the Psychiatry Chief. In addition, the applicant may be required to demonstrate to the Psychiatry Chief knowledge of the risks, benefits, and contraindications of the procedure.

Physicians practicing Medical Acupuncture are expected to establish diagnoses within the traditional framework of Western medical thought, through an appropriate work-up of the patient's condition. It is noted that Acupuncture shall be used in concert with traditional Western medical thought and will not be used as the first alternative unless medical necessity indicates that it is the preferred procedure. The patients' treatment options should also be documented and the rationale for using Medical Acupuncture in each particular situation.

CMC	PVL	UNV	CR	LIN	CAB	UNN	STN	ANS	CLE		Must apply for and maintain Adult or Child and Adolescent Psychiatry Core Privileges (CPSY-1 or CPSY-2)	Number Performed Within The Past 2 Years	Location
		N/A	N/A	N/A	N/A					CPSY-3(a)	Auricular Acupuncture		

Applicant must provide documentation from their training program of at least 60 hours of training in Auricular Acupuncture, deemed satisfactory by the Psychiatry Chief. In addition, the applicant may be required to demonstrate to the Psychiatry Chief knowledge of the risks, benefits, and contraindications of the procedure.

Physicians practicing Auricular Acupuncture are expected to establish diagnoses within the traditional framework of Western medical thought, through an appropriate work-up of the patient's condition. It is noted that Acupuncture shall be used in concert with traditional Western medical thought and will not be used as the first alternative unless medical necessity indicates that it is the preferred procedure. The patients' treatment options should also be documented and the rationale for using Auricular Acupuncture in each particular situation.

PRIVILEGES REQUESTED BY:

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Atrium Health and;

I understand that:

- (a) 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.
- (b) 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.

I attest that I am not currently a user of illegal drugs or do not currently abuse the use of legal drugs.

I attest that I do not have a physical or mental condition which could affect my motor skills or ability to exercise the clinical privileges requested or that I require an accommodation in order to exercise the privileges requested safely and competently.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

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### **CPSY-1 (a) ELECTRO-CONVULSIVE THERAPY**

Applicants for the use of Electro-Convulsive Therapy must be Certified in Psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or have completed training requirements which make them eligible for certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry and must provide documentation of the following items:

#### Credentials:

1. Written verification from psychiatrist's residency training program and/or from supervising psychiatrist of didactic education and training in ECT during residency and of supervisor observation of resident trainee having performed at least ten (10) treatments on at least three (3) patients, with demonstrated acquisition of requisite skills and knowledge, and no more than two (2) years having elapsed since the last administered treatment; **OR**
1. Written verification from a previous Medical Chair, Department Chief, Department Chair, ECT Service Chief (or equivalent position), responsible Hospital Administrator, or Board Certified Psychiatrist's colleague administering ECT to the effect that the psychiatrist performed ECT at his/her institution, delivered at least twenty (20) treatments to at least three (3) different patients with no more than two (2) years having elapsed since the last administered treatment, and had no evidence emerge from Quality Assurance data or other sources of unusual complications, adverse reactions, or undesirable outcomes; **OR**
1. If the applicant has previous experience but neither of the two above have occurred within the past two (2) years, submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Electro-Convulsive Therapy. You must provide documentation of proctoring for two (2) treatments; **OR**
1. Written verification of satisfactory completion of a CME-accredited ECT training program that provided at least twenty (20) hours of Category I credits and involved hands-on treatment experience; **OR**
1. If no previous experience, submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Electro-Convulsive Therapy. You must provide documentation of observing five (5) treatments and proctoring for five (5) treatments; **AND**
2. Signed attestation that the applicant has read and is familiar with the following:
  - (a) The most recent edition of the **APA Task Force Report on ECT**, published by the American Psychiatric Association, Washington, D.C.
  - (b) The **ECT TREATMENT MANUAL** (or a similar operation manual for the ECT instrument which the psychiatrist will be using); **AND**
3. Up-to-date certification in CPR.

#### **REAPPOINTMENT CRITERIA FOR CONTINUED PRIVILEGES (CPSY-1(a)):**

The Physician must perform a minimum of five (5) treatments over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for Electro-Convulsive Therapy privileges. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold Electro-Convulsive Therapy privileges but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

**Atrium Health  
Behavioral Health  
Attestation Statement**

**Required to Obtain Privileges to Perform Electroconvulsive Therapy (ECT)**

I hereby attest that I have completed and am familiar with all the necessary educational readings as outlined below regarding electroconvulsive therapy. I declare that the above statement is true and accurate to the best of my knowledge.

1. APA Task Force report on ECT. Most recent edition.
2. ECT Device Treatment Manual

Physician requesting privileges to perform ECT:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Director or Assistant Medical Director of Brain Stimulation Services

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **CPSY-1 (b) DRUG ASSISTED INTERVIEW TECHNIQUES**

Applicants for the use of drug assisted interview techniques must be Certified in Psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or have completed training requirements which make them eligible for certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry and must provide documentation of the following items:

Provide documentation for one (1) of the following:

1. Written verification from the psychiatrist's residency education program of training in intravenous drug assisted interviewing that included the following:
  - a) Supervised performance of at least five (5) procedures on at least two (2) different patients; **AND**
  - b) Demonstrated acquisition of requisite skills and knowledge; **OR**
1. Written verification of completion within the previous three (3) years of a Category I CME Course in intravenous drug assisted interviewing that included the following:
  - a) Supervised performance of at least five (5) procedures on at least two (2) different patients; **AND**
  - b) Acquisition of requisite skills and knowledge; **OR**
1. Written verification from a current or previous colleague, who is board certified in Psychiatry and practiced at the same hospital or clinic at the same time as the applicant to the effect that the Psychiatrist:
  - a) Performed intravenous drug assisted interviews at that hospital or clinic at least five (5) times on at least two (2) patients; **AND**
  - b) Was not known to have produced adverse outcomes from those interviews; **OR**
1. Written verification of satisfactory completion of at least three (3) intravenous drug assisted interviews on at least two (2) different patients under the supervision and direct observation of a credentialed psychiatrist who is privileged to perform drug assisted interviews with demonstration by the applicant of acquisition of the requisite skills and knowledge; **AND**
2. Up-to-date certification in CPR; **AND**
3. A written, signed attestation that the applicant has read and agrees to abide by the Department of Psychiatry Drug Assisted Interview Policy and Procedure, which is here-by incorporated by reference.

### **CPSY-1 (c) TRANSCRANIAL MAGNETIC STIMULATION (TMS)**

Applicants for the use of Transcranial Magnetic Stimulation (TMS) must be Certified in Psychiatry by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or have completed training requirements which make them eligible for certification by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry and must provide documentation of the following items:

#### Credentials:

1. Written verification from psychiatrist's residency training program and/or from supervising psychiatrist of didactic education and training in TMS during residency and of supervisor observation of resident trainee having performed at least five (5) motor thresholds / treatments on five (5) patients, with demonstrated acquisition of requisite skills and knowledge, and no more than two (2) years having elapsed since the last administered treatment; **OR**
1. Written verification from a previous Medical Chair, Department Chief, Department Chair, BRAIN STIMULATION Service Chief (or equivalent position), responsible Hospital Administrator, or Board Certified Psychiatrist's colleague administering TMS to the effect that the psychiatrist performed TMS at his/her institution, delivered at least ten (10) motor thresholds / treatments to at least ten (10) different patients with no more than two (2) years having elapsed since the last administered treatment, and had no evidence emerge from Quality Assurance data or other sources of unusual complications, adverse reactions, or undesirable outcomes; **OR**
1. If the applicant has previous experience but neither of the two above have occurred within the past two (2) years, submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Transcranial Magnetic Stimulation. You must provide documentation proctoring for two (2) thresholds; **OR**
1. Written verification of satisfactory completion of a CME-accredited TMS training program that provided at least twenty (20) hours of Category I credits and involved hands-on treatment experience; **OR**
1. If no previous experience, submit the PERMISSION TO BE PROCTORED REQUEST FORM requesting concurrent proctoring by a physician who currently holds privileges to perform Transcranial Magnetic Stimulation. You must provide documentation of observing two (2) thresholds and proctoring for two (2) thresholds; **AND**
2. Signed attestation that the applicant has read and is familiar with the following:
  - (a) The most recent edition of the TRANSCRANIAL MAGNETIC STIMULATION in CLINICAL PSYCHIATRY (Edited by Mark S. George, MD & Robert H. Belmaker, MD)
  - (b) The TMS TREATMENT MANUAL of the TMS devices the practitioner will be operating.
  - (c) Chapter 1-3 & Chapter 6 from BRAIN STIMULATION THERAPIES for CLINICIANS (Edmund S. Higgins, MD & Mark S. George, MD); **AND**
3. Up-to-date certification in CPR.

### **REAPPOINTMENT CRITERIA FOR CONTINUED PRIVILEGES (CPSY-1(c)):**

The Physician must perform a minimum of five (5) motor thresholds/treatments over the past two (2) years based on acceptable results of ongoing professional practice evaluation and outcomes to reapply for Transcranial Magnetic Simulation privileges. This will be reviewed at the time of reappointment. Physicians who would like to continue to hold Transcranial Magnetic Simulation privileges but are unable to document the minimal number will be requested to voluntarily withdraw their request for such privileges and to complete the necessary proctoring forms.

**CASE LOG**

Physician's Name: \_\_\_\_\_

Date: \_\_\_\_\_

	DATE	MEDICAL RECORD NUMBER	PROCEDURE TYPE	Name of procedure (as listed on DOP, e.g. CPSY-1(a))
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			<b>TOTAL</b>	

REFERENCE ONLY