

**LAC+USC MEDICAL CENTER & HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION
DELINEATION OF PRIVILEGES FOR THE DEPARTMENT OF PSYCHIATRY**

NAME OF APPLICANT _____ DATE _____

Initial Appointment and/or Additional Privileges Reappointment

Applicant: Check off only those privileges expected to be performed at the site where you will be working. Note that privileges granted may only be exercised at the site(s) and setting(s) recommended by the Department Chair/Chief/Designee. Shaded areas indicate that the privilege is not applicable for that particular entity.

Department Chair/Chief/Designee: Initial the Recommended column for approved privileges. If applicable, check off the “Not Recommended” boxes. Documentation of all privileges must be provided for all privileges on the last page of this form.

REQUESTED				DESCRIPTION OF PRIVILEGES:	RECOMMENDED	NOT RECOMMENDED	
M	E	H	R			Competency	Other
				1. INPATIENT ADMITTING PRIVILEGES: Privilege limited to physicians to include performing history and physical examinations, ordering diagnostic and inpatient treatment plans.			
				2. PSYCHIATRIC EVALUATION AND DIAGNOSIS OF DISORDERS:			
				OF CHILDHOOD (12 years and under)			
				OF EARLY ADOLESCENCE (13-15 years old)			
				OF LATE ADOLESCENCE (16-18 years old)			
				OF ADULTS (ages 18 and older)			
				3. TREATMENT:			
				PSYCHOTHERAPY			
				PSYCHOTROPIC MEDICATION (must be a physician)			
				4. PRIVILEGES requiring special training or certification:			
				PRIVILEGE TO INITIATE L.P.S. INVOLUNTARY DETENTION PROCEDURES (e.g., W.I.C. 5150) (Must be a full-time or part-time physician)			
				ELECTROCONVULSIVE THERAPY (Must be a full-time or part-time physician)			
				MODERATE SEDATION (e.g., amytal interview) (Must be a full-time or part-time physician)			
				PSYCHOLOGICAL TESTING (Must have a Ph.D. or Psy.D.)			
				5. SPECIAL CONDITIONS / EXCEPTIONS / LIMITATIONS / OTHER:			

M = LAC+USC Medical Center
E = El Monte Comprehensive Health Center
H = Hudson Comprehensive Health Center
R = Roybal Comprehensive Health Center

PRIVILEGES NOT INCLUDED ON THIS FORM: A request to perform any procedure or treatment not included on this form must be submitted to the Attending Staff Office and will be forwarded to the appropriate review committee to determine the need for development of specific criteria, personnel & equipment requirements.

TEMPORARY CLINICAL PRIVILEGES: In the case of an emergency, any individual who has been granted clinical privileges is permitted to do everything possible within the scope of license, to save a patient's life or to save a patient from serious harm, regardless of staff status or privileges granted as per the LAC+USC Attending Staff Association Bylaws.

ACKNOWLEDGMENT OF PRACTITIONER:

I hereby certify that I have no physical or mental impairment which would interfere with my practice, and 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 in each group of procedures requested. I understand that in making this request I am bound by the LAC+USC Bylaws and/or policies of the hospital and medical staff.

APPLICANT'S SIGNATURE

DATE

Department Chair/Chief/Designee:

If there are any recommendations of privileges that need to be modified or have conditions added, indicate here:

Privilege #:

Condition/Modification/Explanation: _____

If privileges are NOT recommended based on COMPETENCY, provide explanation:

Privilege #:

Explanation for NOT recommending based on
COMPETENCY:

If supplemental documentation provided, check here:

I have reviewed the requested clinical privileges and the supporting documentation for the above-named applicant and recommend requested privileges as noted above.

SIGNATURE OF THE DEPARTMENT CHAIR/CHIEF/DESIGNEE

DATE

APPROVED BY THE CREDENTIALS & PRIVILEGES COMMITTEE ON:

APPROVED BY THE EXECUTIVE COMMITTEE ON:

APPROVED BY GOVERNING BODY ON:

PERIOD ENDING:

Name: _____

Psychiatry Revised 2-2012