Psychology KHDO

Delineation of Privileges

Applicant's Name:

Instructions:

1. Click the **Request** checkbox to request a group of privileges.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign/Date form and Submit with required documentation.
5. Applicant have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving doubts related to qualification of requested privileges.

NOTE:
Privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Required Qualifications	
Membership	I request the following clinical privileges, and I am aware that a denial of privileges relating to a practitioner's professional competence or professional conduct will result in the hospital submitting a report to the National Practitioner Data Bank.
Certification	All privileges require licesnsure as a psychologist in the State of Ohio.
Additional Qualifications	Clinical supervision also requires experience in supervising allied health professionals in area of practice, i.e., psychiatry or chemical dependency.

Primary Privileges Psychology

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request*	Department/Section Chair ☐	Credentials Committee Chair ☐
	Area of Specialty or Subspecialty		
☐	Clincal supervision of therapy staff	☐	☐
☐	Diagnostic summary	☐	☐
☐	Discharge planning	☐	☐
☐	Family/Significant other therapy	☐	☐
☐	Group therapy	☐	☐
☐	Individual therapy	☐	☐
☐	Mental status evaluation	☐	☐
☐	Pre-Admission assessment	☐	☐
☐	Psychological evaluation	☐	☐
☐	Psychodiagnostic testing	☐	☐
☐	Treatment planning	☐	☐
	Other privileges		
☐	Cognitive-behavioral therapy for pain management	☐	☐

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I am entitled to perform and that I wish to exercise at Kettering Health Dayton/Kettering Health Washington Township 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 situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Practitioner's Signature _____ Date _____

Clinical Service Chair Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and make the following recommendation(s):

☐	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	Recommend privileges with the following conditions/modifications/deletions (listed below)

Privilege	Condition/Modification/Deletion/Explanation

Clinical Service Chair Recommendation - Additional Comments

Chair, Department/Section

Date

Chair, Credentials Committee

Date

Submit