



Psychology Soin & KHGM
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. Applicants 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 and 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

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| Membership | To be eligible to apply for clinical privileges as a psychologist, the applicant must meet the following criteria: |
| Education/Training | <p>Applicant must possess an earned doctorate degree (PhD or PsyD) in psychology from an accredited educational institution and have completed at least two years of clinical experience in an organized healthcare setting supervised by a licensed psychologist, one year of which must have been post-doctoral.</p> <p style="text-align: center;">AND</p> <p>An internship endorsed by the American Psychological Association or an internship that meets the criteria established by the State Board of Psychology in Ohio at the time of licensure.</p> |
| Certification | Current license to practice issued by the Ohio State Board of Examiners of Psychologists. |
| Clinical Experience (Initial) | The successful applicant must be able to demonstrate provision of care, treatment, or services reflective of the scope of privileges requested to at least 30 patients during the past 12 months. |
| Clinical Experience (Reappointment) | Current demonstrated competence and an adequate volume of experience 24 patients with acceptable results reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. |
| Additional Qualifications | Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the governing body. |

Primary Privileges Psychology

| Request | | <i>Request all privileges listed below.</i> |
|---------|------|--|
| KHGM | SOIN | Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request. |
| | | - Currently granted privileges |
| | | Diagnose and provide treatment and consultation to children, adolescent, and adult patients who suffer from mental, behavioral, or emotional disorders. Provide formal evaluation and testing. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. |
| | | Procedures |
| | | Family assessment/therapy |
| | | Group therapy |
| | | Marital or couples therapy |
| | | Psychological assessment |
| | | Psychotherapy |

Behavioral Modification Therapy

Qualifications

Education/Training Completion of one year of approved verifiable graduate training in a program approved by the American Psychological Association in which the modality was specifically taught, and/or must be supervised by a fully licensed psychologist independently privileged in this area.

Clinical Experience (Initial) Demonstrated current competence and evidence of the performance of at least 5 behavioral modification therapy procedures in the past 12 months.

Clinical Experience (Reappointment) Demonstrated current competence and the performance of at least 5 procedures in the past 24 months.

| Request | | <i>Request all privileges listed below.</i> |
|---------|------|--|
| KHGM | SOIN | Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request. |
| | | - Currently granted privileges |
| | | Behavioral modification therapy |

Biofeedback Therapy

Qualifications

Education/Training Certification by the Biofeedback Certification Institute of America or documented equivalent training and experience.

Clinical Experience (Initial) Demonstrated current competence and evidence of the performance of at least 5 biofeedback therapy procedures in the past 12 months.

Clinical Experience (Reappointment) Demonstrated current competence and the performance of at least 5 procedures in the past 24 months.

| Request | | <i>Request all privileges listed below.</i> |
|---------|------|--|
| KHGM | SOIN | Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request. |
| | | - Currently granted privileges |
| | | Biofeedback Therapy |

Neuropsychological Testing

Qualifications

- Education/Training** Successful completion of systematic didactic and experiential training in neuropsychology and neuroscience at a regionally accredited university and two or more years of appropriate supervised training applying neuropsychological services in a clinical setting.
- Clinical Experience (Initial)** Demonstrated current competence and evidence of the performance of at least 5 neuropsychological testing procedures in the past 12 months.
- Clinical Experience (Reappointment)** Demonstrated current competence and the performance of at least 5 neuropsychological testing procedures in the past 24 months.

| Request | <i>Request all privileges listed below.</i> |
|--------------|---|
| KHGM SOIN | Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request. |
| | - Currently granted privileges |
| | Neuropsychological Testing |

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Kettering Health Greene Memorial and/or Soin Medical Center, and I understand that:

- A. In exercising any clinical privileges granted, I am constrained by applicable 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):

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| | 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 |
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| Clinical Service Chair Recommendation - Additional Comments |
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Clinical Service Chair Signature

Date