

B. Clinical Assessment Privileges

- 9. Differential diagnostic assessment
- 10. Forensic assessment
- 11. Psychopharmacologic response monitoring
- 12. Vocational/education assessment
- 13. Psychosocial assessment
- 14. Other assessment, as indicated

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full

C. Clinical Treatment Privileges

- 1. Individual psychotherapy
- 2. Group psychotherapy
- 3. Family psychotherapy
- 4. Behavior modification
- 5. Hypnosis
- 6. Biofeedback
- 7. Emergency room/crisis intervention
- 8. Pain management
- 9. Substance abuse reduction
- 10. Stress management
- 11. Rehabilitation services
- 12. Other (specify): _____

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full

II. CONSULTING PRIVILEGES

A. Within the Facility

- 1. Consultation liaison to other services
- 2. Organizational developmental services
- 3. Staff development
- 4. Wellness promotion

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full

B. External to the Facility

- 1. Professional and community education
- 2. Community development

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full

B. External to the Facility

3. Disease/injury prevention

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full

III. PROGRAMMATIC ACTIVITIES

- A. Program planning and evaluation**
- B. Collection/interpretation of caseload data**
- C. Ascertainment of population mental health needs**
- D. Supervise staff and trainees**
- E. Ensure accreditation/approval**

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full
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PSYCHOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

Applicant

Date

2. I hereby recommend the clinical privileges as indicated.

Supervisor/Consultant

Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges:
(check one)

As noted.

With the following exceptions, deletions, additions, or conditions:

Clinical Director

Date

4. I hereby recommend the applicant for clinical privileges.

Service Unit Director

Date

5. Privileges are hereby granted: (check one)

As noted.

With the following exceptions, deletions, additions, or conditions:

Chairperson of the
Governing Body

Date

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917-0009). Please *do not send* this form to this address.
