

## AUDIOLOGIC PRIVILEGES REQUEST FORM

### INTRODUCTION

This Audiologic Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. The request for privileges must reflect both the applicant's and the facility's/staff's ability to carry out or support the various functions.

### INSTRUCTIONS FOR COMPLETING THE FORM

**Applicant:** With a check mark in the appropriate location, indicate for each item, if you are requesting privileges. Be sure to sign the request as indicated on page 2.

**Discipline-specific supervisor or consultant:** Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location. Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the governing body when granting or not granting privileges.

### I. DIAGNOSTIC

- A. Pure-tone audiometry
- B. Speech audiometry
- C. Site of lesions tests (auditory)
- D. Acoustic impedance measurements
- E. Electronystagmography
- F. Pediatric audiometry
- G. Evoked potential (auditory)

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### II. AMPLIFICATION

- A. Assessment of potential success of amplification
- B. Hearing aid evaluation
- C. Issuing hearing aids

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### III. REHABILITATION

- A. Auditory training
- B. Manual communication
- C. Speech reading
- D. Nonverbal communication

Applicant Requests		Supervisor/ Consultant Recommends		
Ltd.	Full	N.R.	Ltd.	Full
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## AUDIOLOGIC 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

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### ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 5 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.

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