DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date: 6/30/2016

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

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

II. AMPLIFICATION

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Assessment of potential success of amplification	☐	☐	☐	☐	☐
B. Hearing aid evaluation	☐	☐	☐	☐	☐
C. Issuing hearing aids	☐	☐	☐	☐	☐

III. REHABILITATION

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Auditory training	☐	☐	☐	☐	☐
B. Manual communication	☐	☐	☐	☐	☐
C. Speech reading	☐	☐	☐	☐	☐
D. Nonverbal communication					

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

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.