DELINEATION OF CLINICAL PRIVILEGES – PSYCHIATRY

NAME OF PROVIDER *(Last, First, MI)*	FACILITY **Salinas Valley State Prison**

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures list, line through and initial any criteria / applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections of this list or privileges will require you to submit a new form.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the Local Governing Body who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 – Fully competent to perform	1 – Approved as fully competent
2 – Modification requested *(Justification attached)*	2 – Modification Required *(Justification noted)*
3 – Supervision requested	3 – Supervision required
4 – Not requested due to lack of expertise	4 – Not approved, insufficient expertise
5 – Not requested due to lack of facility support	5 – Not approved, insufficient facility support

SECTION 1 – CLINICAL PRIVILEGES

Category I.

Physicians not board eligible in psychiatry with little or no residency training, but with considerable expertise in the care of mental disorders and qualified for the general practice of medicine.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.

A Psychiatrist who is board eligible in Psychiatry.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.

Psychiatrists who are board certified by the American Board of Psychiatry and Neurology or its equivalent.

Requested	Approved	
		Category III clinical privileges

Category IV. Includes Categories I, II and III.

Specialized fellowship training beyond board eligibility or board certification in General Psychiatry. Requires extensive subspecialty fellowship training or experience in the areas noted below..

Requested	Approved	
		Category IV clinical privileges

Subspecialties

Requested	Approved		Requested	Approved	
		a. Psychoanalysis			e. Geriatric Psychiatry
		b. Child Psychoanalysis			f. Consultant-Liaison Psychiatry
		c. Forensic Psychiatry			g. Additions Medicine
		d. Administrative Psychiatry			h. Psychopharmacology

Privileges Requested

Requested	Approved		Requested	Approved	
		a. Assessment & Diagnosis of Mental Disorders			e. Somatic Therapy
		b. Inpatient Psychiatric Treatment			(1) Psychopharmacotherapy
		c. Alcohol/Substance Abuse Treatment			(2) Biofeedback Therapy
		(1) Residential Treatment Services			(3) Electro-Convulsive Therapy
		d. Adult Psychotherapy			(4) Amytal Interview
		(1) Individual			

Privileges Requested *(Continued)*					
Requested	Approved		Requested	Approved	
		f. Specialized Skills			
		(1) Forensic Psychiatry			(6) Gestalt Therapy
		(2) Psychoanalysis			(7) Hypnotherapy
					(8) Evaluations for Dangerousness: Suicidality/Homicidality/Assaultive Potential
		(4) Geriatric Psychiatry			g. Research
		(5) Behavior Therapy			h. Other *(Specify)*

COMMENTS

	SIGNATURE OF PROVIDER	DATE

SECTION II – SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT / SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE

SECTION III – CREDENTIALS COMMITTEE RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval (Specify below) ☐

COMMENTS

CREDENTIALS COMMITTEE CHAIRPERSON *(Typed name and title)*	SIGNATURE	DATE

APPROVAL OF CLINICAL PRIVILEGES APPOINTMENT

1. NAME OF PROVIDER *(Last, First, MI)*	2. PERIOD OF EVALUATION From To

3. PRIVILEGES REQUESTED *(Specify discipline(s))*

☐ Dentistry	☐ Occupational Therapy	☐ Psychiatry
☐ Dietetics	☐ Optometry	☐ Psychology
☐ Emergency Medicine	☐ Physical Therapy	☐ Social Work
☐ Family Practice	☐ Internal Medicine	☐ Surgery
☐ Neurology	☐ Podiatry	☐ Other

4. RECOMMENDATIONS. The following department / service and credentials committee recommendations are based on a review of the provider's verified licensure, education and training, experience, physical and mental capacities to perform the requested privileges and demonstrated current competence. Exceptions or stipulations are noted below in Block 5.

a. MEDICAL TREATMENT FACILITY / DENTAL	b. APPOINTMENT STATUS ☐ Initial ☐ Temporary ☐ Active ☐ None ☐ Affiliate	c. CATETGORY OF PRIVILEGES ☐ Regular ☐ Supervised ☐ Temporary
d. ADMITTING PRIVILEGES ☐ Requested ☐ Granted ☐ Not Requested ☐ Not Granted	e. PLAN OF SUPERVISION ☐ Required ☐ Not Required	f. NAME OF SUPERVISOR *(if applicable)*

g. DEPARTMENT HEAD *(Typed Name & Title)*	h. SIGNATURE	i. DATE

j. The Credentials Committee met on _______________ to review the merits of this provider's application for staff appointment and / or clinical privileges. It is the decision of this committee to ☐ CONCUR ☐ NOT CONCUR with the above recommendations. Exceptions or stipulations are noted below in Block 5.

k. CREDENTIALS COMMITTEE CHAIRPERSON *(Typed Name & Title)*	l. SIGNATURE	m. DATE

5. REMARKS

6. The Executive Committee of the Medical Staff reviewed this provider's request for privileges and medical staff appointment, as applicable, on _______________. It is the decision of this committee to ☐ CONCUR ☐ NOT CONCUR with the above recommendations.

6a. CHIEF OF STAFF *(Typed Name)*	6b. SIGNATURE	6c. DATE

7. APPROVAL. Based on my review of the information submitted in support of the provider's licensure, education and training, and his / her demonstrated competence, privileges are approved and medical staff membership is awarded as requested. The period for which clinical privileges and membership are in effect is as noted above in Block 2.

7a. CHAIR OF LOCAL GOVERNING BODY *(Typed Name)*	7b. SIGNATURE	7c. DATE