



Request for Specific Clinical Privileges

Applicant Name *(please print)*: _____

Group Name *(please print)*: _____

Please Check Highest Level of Licensure

- | | | | |
|---------------------------------------|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychologist w/RX | <input type="checkbox"/> LISW |
| <input type="checkbox"/> LPCC | <input type="checkbox"/> LMFT | <input type="checkbox"/> CNP | <input type="checkbox"/> Nurse w/RX |
| <input type="checkbox"/> CNS | <input type="checkbox"/> LADAC | <input type="checkbox"/> Other (Please Specify) _____ | |

Requests for **new privileges** or for **privileges beyond** what you already have **must** be accompanied by supporting documentation to verify your qualifications. Please refer to the enclosed **Privilege Criteria Sheet**.

Please indicate privileges being requested:

	YES	NO
Adults (A)	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (T)	<input type="checkbox"/>	<input type="checkbox"/>
Children (C)	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment (SA)	<input type="checkbox"/>	<input type="checkbox"/>
Suboxone Therapy (ST) <small>(MD or DO Only – requires DEA or CSR)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Full Battery Neuropsych Testing (NT) <small>(Psychologists Only)</small>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Signature: _____ Date: _____

↓↓↓ FOR INTERNAL USE ONLY ↓↓↓

Initial Review

Recommended for: A T C SA ST NT

Need Additional Information for: A T C SA ST NT

Comments: _____

Clinical Reviewer: _____ Date: _____

Committee Chair: _____ Date: _____

Subsequent Review (use as needed)

Recommended for: A T C SA ST NT

Comments: _____

Clinical Reviewer: _____ Date: _____

Committee Chair: _____ Date: _____