



PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: _____
Please Print

✓	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)
	ADULT PSYCHIATRY (18 years of age and older)
	Emergency Room and Crisis Team consultations
	Brief Psychotherapy
	Admit and treat inpatients
	Psychiatric Assessment
	Medication Management

Acknowledgement of the Practitioner:

I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and that I wish to exercise at the Psychiatric Health Facility. I understand that exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

Applicant's Signature: _____ Date: _____

PRIVILEGE APPROVAL

PHF Medical Director Signature: _____ Date: _____

PHF Medical Practice Committee Approval Date: _____

PHF Governing Board Approval Date: _____