SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

PSYCHIATRIC HEALTH FACILITY PSYCHOLOGIST PRIVILEGE CHECKLIST

Provider Name: _____
Please Print

✓	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)
	ADULT PSYCHOLOGICAL SERVICES (18 years of age and older)
	Family assessment/therapy
	Group Therapy
	Marital or couples therapy
	Psychological assessment
	Psychotherapy

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: _____