TO LESLIE LUNDT 681-4269

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

Alice Gleghorn, PhD
Director

# PSYCHIATRIC HEALTH FACILITY INTERNAL MEDICINE PRIVILEGE CHECKLIST

Provider Name: Daniel Litten
*Please Print*

| ✓ | CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.) |
|---|---|
| | ADULT INTERNAL MEDICINE (18 years of age and older) |
| ✓ | Admission Medical History & Physical |
| ✓ | Treat patients in the hospital and CSU |
| ✓ | J&D – abscesses, cysts and hematomas |
| ✓ | Suture removal |

**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: [signature] Date: 9/19/16

PRIVILEGE APPROVAL

PHF Medical Director Signature: [signature] Date: 9/20/16

PHF Medical Practice Committee Approval Date: 9/21/16

PHF Governing Board Approval Date: _____

From: **Lundt, MD, Leslie** llundt@co.santa-barbara.ca.us
Subject: URGENT privileges please sign and scan back to me
Date: September 19, 2016 at 5:48 PM
To: enrico cerrato cerrato.rico@gmail.com

LM

I need this tomorrow please

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

Alice Gleghorn, PhD
Director

# PSYCHIATRIC HEALTH FACILITY INTERNAL MEDICINE PRIVILEGE CHECKLIST

Provider Name: Enrico Cerrato
*Please Print*

| | |
|---|---|
| ✓ | CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.) |
| | ADULT INTERNAL MEDICINE (18 years of age and older) |
| ✓ | Admission Medical History & Physical |
| ✓ | Treat patients in the hospital and CSU |
| ✓ | I&D – abscesses, cysts and hematomas |
| ✓ | Suture removal |

**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: E Cerrato Date: 9/19/16

**PRIVILEGE APPROVAL**

PHF Medical Director Signature: [signature] Date: 9.20.16

PHF Medical Practice Committee Approval Date: 9/21/16

PHF Governing Board Approval Date: _____

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: Cecile Lyons
*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: Cecile Lyons, PhD Date: 9/19/16

**PRIVILEGE APPROVAL**

PHF Medical Director Signature: [signature] Date: 9/20/16

PHF Medical Practice Committee Approval Date: 9/21/16

PHF Governing Board Approval Date: _____

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

Alice Gleghorn, PhD
Director

# PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: Ole Behrendtsen
*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: Ole Behrendtsen Date: 9/22/16

**PRIVILEGE APPROVAL**

PHF Medical Director Signature: Date: 9/22/16

PHF Medical Practice Committee Approval Date: 9/26/16

PHF Governing Board Approval Date: _____

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

Alice Gleghorn, PhD
Director

# PSYCHIATRIC HEALTH FACILITY INTERNAL MEDICINE PRIVILEGE CHECKLIST

Provider Name: Salman Haq
*Please Print*

| | |
|---|---|
| ✓ | CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.) |
| | ADULT INTERNAL MEDICINE (18 years of age and older) |
| ✓ | Admission Medical History & Physical |
| ✓ | Treat patients in the hospital and CSU |
| ✓ | I&D – abscesses, cysts and hematomas |
| ✓ | Suture removal |

**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: M Salman Haq Date: 9/22/16

**PRIVILEGE APPROVAL**

PHF Medical Director Signature: [signature] Date: 9/23/16

PHF Medical Practice Committee Approval Date: 9/26/16

PHF Governing Board Approval Date: _____