



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: Micah Hoffman, MD
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: 4/7/17

PHF Medical Director Signature: Date: 4/20/17

PHF Medical Practice Committee Approval Date: _____

PHF Governing Board Approval Date: _____



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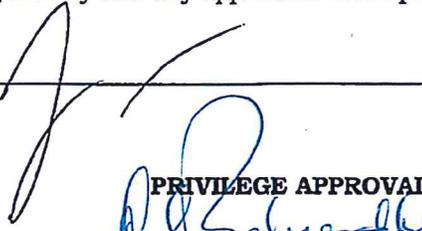
PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: Jonathan Terry, DO
Please Print

<input checked="" type="checkbox"/>	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)	
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Applicant's Signature:  Date: 4/6/17

PHF Medical Director Signature:  Date: 4/20/17

PHF Medical Practice Committee Approval Date: _____

PHF Governing Board Approval Date: _____



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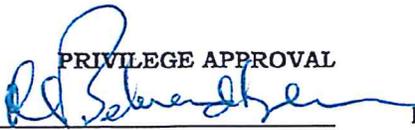
Provider Name: Michael Bolton, MD
Please Print

✓	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)
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✓	Emergency Room and Crisis Team consultations
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Applicant's Signature:  Date: 4/12/17

PHF Medical Director Signature:  Date: 4/20/17

PHF Medical Practice Committee Approval Date: _____

PHF Governing Board Approval Date: _____



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PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: Brian McKinney, MD
Please Print

✓	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)
	ADULT PSYCHIATRY (18 years of age and older)
✓	Emergency Room and Crisis Team consultations
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✓	Medication Management

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Applicant's Signature: Brian McKinney MD Date: 4/4/2017

PHF Medical Director Signature: [Signature] **PRIVILEGE APPROVAL** Date: 4/20/17

PHF Medical Practice Committee Approval Date: _____

PHF Governing Board Approval Date: _____



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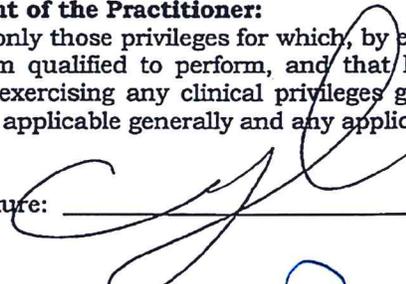
PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: Mottsin Thomas, MD
Please Print

<input checked="" type="checkbox"/>	CHECK PRIVILEGES REQUESTED (Refer to attached guidelines.)	
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Applicant's Signature:  Date: 4/6/17

PHF Medical Director Signature:  Date: 4/20/17

PHF Medical Practice Committee Approval Date: _____
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PSYCHIATRIC HEALTH FACILITY PSYCHIATRY PRIVILEGE CHECKLIST

Provider Name: Joshua Flatow, MD
Please Print

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Applicant's Signature: Date: 4/17/17

PHF Medical Director Signature: Date: 4/25/17

PHF Medical Practice Committee Approval Date: 4/10/17

PHF Governing Board Approval Date: _____