



Core Privileges

PSYCHIATRY SERVICE

QUALIFICATIONS: To be eligible for core privileges in Psychiatry Service, the applicant must be under employment/contract service agreement as specified by Teche Regional Medical Center's Board of Trustees, comply with all contractual requirements set forth therein, and meet the following qualifications:

- MD or DO with successful completion of a four year ACGME or AOA-accredited residency training program in psychiatry;
- Current certification or active participation in the examination process leading to certification in psychiatry by the American Board of Psychiatry & Neurology, or equivalent credentials as determined by the Service Chief;
- Documentation or attestation of that s/he has provided inpatient, outpatient, or consultative services for at least 100 patients during the past two years.

(R)= Recommended as Requested (A)=Approved as Requested (C)=Recommended with Condition(s) (N)=Not Recommended

Requested						
Yes	No	CORE PRIVILEGES	(R)	(A)	(N)	(C) Condition/Reason(s)
		<p>General Psychiatry: Core privileges to admit, evaluate (both inpatient and outpatient), diagnose, and provide treatment or consultative services to patients at or above the age of 18 presenting with mental, behavioral, or emotional disorders such as depression, anxiety, substance abuse, psychosis, developmental disabilities, sexual dysfunction, or adjustment reactions.</p> <p>Core privileges include but are not necessarily limited to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Consultations with physicians in other fields regarding mental, behavioral, emotional, and geriatric psychiatric disorders <input type="checkbox"/> Psychopharmacology for physicians <input type="checkbox"/> Providing and supervising individual, group and family therapy <input type="checkbox"/> Use and interpretation of psychological tests <input type="checkbox"/> Behavioral modification <input type="checkbox"/> Consultation to the courts <input type="checkbox"/> Emergency psychiatry 				

I attest to providing psychiatric services to at least 100 patients during the past two years and have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Teche Regional Medical Center.

Signature of Applicant

Date

Printed Name

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommended the privileges as indicated above.

Signature of Service or Department Chair

Date

Board of Trustees' Decision

Teche Regional Medical Center's Board of Trustees

Does

Does not grant clinical privileges as requested

(if "does not" grant, give reasons in letter to the applicant with a copy of privilege list)

Secretary, Board of Trustees

Date



HEALTH STATEMENT

TO CHIEF OF SERVICE / CHIEF OF STAFF

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY COGNITIVE AND MOTOR SKILLS TO SAFELY PERFORM ALL PRIVILEGES REQUESTED AND DECLARE MYSELF TO BE FREE FROM ANY CONDITION, ILLNESS, OR INFECTIOUS DISEASE THAT COULD COMPROMISE PATIENT CARE OR MY ABILITY TO PERFORM THE PRIVILEGES REQUESTED.

YES NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION OR ILLNESS (INCLUDING ANY CHEMICAL OR ALCOHOL DEPENDENCY) WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED WITHOUT SPECIAL ACCOMMODATIONS IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS, OR MAY BE INFECTIOUS, COULD AFFECT MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR COULD POTENTIALLY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

YES NO

If yes, please explain:

3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST? YES NO
If yes, please give date of positive skin test. _____
If no, when was your last PPD test? _____

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND CLINICALLY COMPETENT TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

SIGNATURE OF APPLICANT

DATE

CHIEF OF SERVICE

DATE