



# CIBOLA GENERAL HOSPITAL

1016 ROOSEVELT • GRANTS, NM 87020 • (505) 287-4446 • FAX (505) 287-5309

## REQUEST FOR CLINICAL PRIVILEGES: SOCIAL SERVICES

Name (please print): \_\_\_\_\_

**Instructions: Place a ( √ ) next to each procedure requested.**

Procedure Classification	Privilege Requested	Privilege Recommended	Special Conditions
Social Services – Clinical			
Mental Health – Clinical			
Substance Abuse – Clinical			

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Appointment Recommended    Appointment Not Recommended    Appointment Deferred

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chairman, Executive Committee

Appointed

Disapproved

Deferred

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chairman, Board of Directors



**HEALTH STATEMENT**

Do you presently have a physical or mental health condition which would affect or is likely to affect your ability to perform professional or medical staff duties as a physician/allied health professional?:

\_\_\_\_\_ Yes    \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

During the last two years, have you been hospitalized or received any other type of institutional care for a health problem?:

\_\_\_\_\_ Yes    \_\_\_\_\_ No

Significant finding: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

**\*\*\*\*\*IMPORTANT – MUST BE SIGNED BY VERIFYING PHYSICIAN\*\*\*\*\***

I affirm to the best of my knowledge that the above mentioned physician has no physical or psychological impairments that would impede his/her ability to perform quality health care services.

\_\_\_\_\_  
(Signature of verifying physician)

Date: \_\_\_\_\_