

REQUEST FOR CLINICAL PRIVILEGES: DIETITIAN

Name (please print): _____

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

Procedure Classification	Privilege Requested	Privilege Recommended	Special Conditions
To evaluate the nutritional status of patients and to make nutrition recommendations to the medical team as needed. To provide diet counseling, both inpatient and outpatient, as dietary concerns and education needs arise.			

Signature

Date

Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

Chairman, Executive Committee

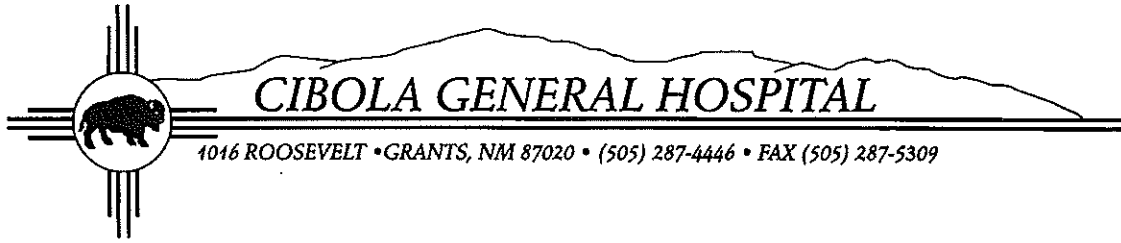
Appointed

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: _____