



REQUEST FOR CLINICAL PRIVILEGES: SPEECH THERAPIST

Name (please print): _____

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

Procedure Classification	Privilege Requested	Privilege Recommended	Special Conditions
Provide speech language pathology services to both inpatient and outpatient population.			
Diagnosis and treatment of communicative, cognitive and swallowing disorders.			

Signature

Date

Appointment Recommended Appointment Not Recommended Appointment Deferred

Date

Chairman, Executive Committee

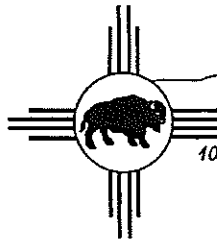
Appointed

Disapproved

Deferred

Date

Chairman, Board of Directors



CIBOLA GENERAL HOSPITAL

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

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: _____