



### Request for Specific Clinical Privileges

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

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

*Please Check Highest Level of Licensure*

- Psychiatrist   
  Psychologist   
  Psychologist w/RX   
  LISW  
 LPCC   
  LMFT   
  CNP   
  Nurse w/RX  
 CNS   
  LADAC   
  Other (Please Specify) \_\_\_\_\_

Requests for **new privileges** or for **privileges beyond** what you already have **must** be accompanied by supporting documentation to verify your qualifications. Please refer to the enclosed **Privilege Criteria Sheet**.

Please indicate privileges being requested:

	YES	NO
Adults (A)	<input type="checkbox"/>	<input type="checkbox"/>
Adolescents (T)	<input type="checkbox"/>	<input type="checkbox"/>
Children (C)	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment (SA)	<input type="checkbox"/>	<input type="checkbox"/>
Suboxone Therapy (ST) <small>(MD or DO Only – requires DEA or CSR)</small>	<input type="checkbox"/>	<input type="checkbox"/>
Full Battery Neuropsych Testing (NT) <small>(Psychologists Only)</small>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### ↓↓↓ FOR INTERNAL USE ONLY ↓↓↓

#### Initial Review

Recommended for:             A     T     C     SA     ST     NT

Need Additional Information for:     A     T     C     SA     ST     NT

Comments: \_\_\_\_\_

Clinical Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Committee Chair: \_\_\_\_\_ Date: \_\_\_\_\_

#### Subsequent Review (use as needed)

Recommended for:             A     T     C     SA     ST     NT

Comments: \_\_\_\_\_

Clinical Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

Committee Chair: \_\_\_\_\_ Date: \_\_\_\_\_