

CARLSBAD MEDICAL CENTER

PSYCHIATRY  
APPLICATION FOR PRIVILEGES

NAME OF APPLICANT: \_\_\_\_\_

BOARD CERTIFICATION: \_\_\_\_\_ DATE: \_\_\_\_\_

All practitioners requesting Psychiatry privileges are to be board certified by the American Board of Psychiatry and Neurology (ABPN) or fully trained by an accredited Psychiatry residency program recognized by the American Board of Medical Specialties (ABMS).

R = Requested		G = Granted		D = Denied		
R	G	D				
[ ]	[ ]	[ ]				Admitting and Attending Privileges
[ ]	[ ]	[ ]				Adult
[ ]	[ ]	[ ]				Adolescent
[ ]	[ ]	[ ]				Consultation Only
[ ]	[ ]	[ ]				Child Psychiatry
[ ]	[ ]	[ ]				Adolescent Psychiatry
[ ]	[ ]	[ ]				Adult Psychiatry
[ ]	[ ]	[ ]				Geriatric Psychiatry
[ ]	[ ]	[ ]				Family and Marital Therapy
[ ]	[ ]	[ ]				Group Therapy
						Psychotherapy
[ ]	[ ]	[ ]				Supportive
[ ]	[ ]	[ ]				Insight-Oriented (Psychodynamic)
[ ]	[ ]	[ ]				Behavioral
[ ]	[ ]	[ ]				Drug and Alcohol Addiction Withdrawal
[ ]	[ ]	[ ]				Psychopharmacotherapy
[ ]	[ ]	[ ]				Emergency Room Psychiatry
[ ]	[ ]	[ ]				Neuropsychological Testing
[ ]	[ ]	[ ]				Forensic Psychiatry
[ ]	[ ]	[ ]				Administrative Psychiatry
[ ]	[ ]	[ ]				General Medical Care of Psychiatric Patients

OTHER PROCEDURES

[ ] [ ] [ ] Specify: \_\_\_\_\_

[ ] [ ] [ ] Specify: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

I certify that I have had the necessary training and experience to perform the procedures that I have requested.

\_\_\_\_\_  
NAME OF APPLICANT (Please Print)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**APPROVALS**

All privilege delineations have been individually considered and have been recommended based upon the practitioner's specialty, licensure, specific training, experience, health status, current competence and peer recommendations.

APPLICANT MAY PERFORM PRIVILEGES AND PROCEDURES AS INDICATED:

EXCEPTIONS/LIMITATIONS:

\_\_\_\_\_  
(specify)  
\_\_\_\_\_

\_\_\_\_\_  
Medicine Department Chairperson

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Executive Committee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Board of Trustees

\_\_\_\_\_  
Date



### **AUTHORIZATION FOR BACKGROUND CHECK**

By signing below, I grant permission to the Hospital, its medical staff and representatives ("Hospital") to obtain an investigative report, to include state and federal criminal records and driving arrest records, for purposes of processing my medical staff application. I understand that I may request the Hospital to disclose the nature and scope of the investigation requested within five (5) days of my written request made within a reasonable time after the Hospital obtains the information. I also understand that I am entitled to request a summary of my rights with respect to consumer reporting agencies.

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Print Name

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Signature

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Date