

Delineation Practice Prerogatives--PSYCHOLOGY

Please indicate by a check in the requested column those privileges, which are commensurate with your clinical ability, training, and experience for which you are applying.

PRACTICE PEROGATIVES:	Requested	Not Requested	Approved	Denied
Individual Therapy				
Family therapy				
Group Therapy				
Bio feedback/Stress Management				
Psychological Testing				
Neuropsychological Evaluation/Testing				

Your initials as used in Medical Records _____

Your signature as used in Medical Records _____

I, _____, hereby request privileges in the specialty of Psychology as indicated. I understand that privileges requested may differ from those approved. I further understand that this request does not preclude me from requesting additional privileges in the future.

 Physician

 Date

APPROVAL: Comments: _____ _____	
_____ Medical Director	_____ Date
_____ Governing Body	_____ Date