Qualifications
To be eligible for adult and/or geriatric core privileges in the Department of Psychiatry, the applicant must meet the following qualifications:

- MD or DO;
- Successful completion of an ACGME or AOA recognized accredited residency in psychiatry;
- Currently a PGY3 or higher resident in good standing in an ACGME or AOA recognized accredited psychiatry residency program;
- Demonstration of the provision of inpatient, outpatient or consultative services to at least 30 (10 for residents) patients in the past year;

Privileges included in the Adult and/or Geriatric Core Privileges with observation requirements

☐ I request Adult and/or Geriatric Core Privileges  ☐ I do not request Adult and/or Geriatric Core Privileges

Privileges to admit, consult, evaluate, diagnose, and provide non-surgical treatment to patients at or above the age of 17 who suffer from mental, behavioral or emotional disorders.
Core privileges include, but are not limited to: psychiatric assessment, psychotherapy, and psychopharmacotherapy.

Observation requirements
First six (6) cases will be retrospectively reviewed.

Provisional year chart review requirement
All of the extension cases will be retrospectively reviewed, during the quality improvement process, during the first year at 6 and 12month intervals.

If there is not a sufficient level of activity during the provisional period, recommendations for privileges or an extension of provisional status will be at the discretion of the department Chairman.
Qualifications
To be eligible for child and adolescent core privileges in the Department of Psychiatry, the applicant must meet the following qualifications:

- MD or DO;
- Successful completion of a ACGME or AOA-recognized accredited residency in psychiatry is required for physicians completing medical school in 1995 and thereafter;
- or
- Currently a PGY3 or higher resident in good standing in an ACGME or AOA-recognized accredited psychiatry residency program;
- and
- Certification by the ABPN or AOBPN in psychiatry and certification in child psychiatry;
- or
- Specialty training in adolescent and child psychiatry medicine during residency of at least 6 months on a consultation service either inpatient or outpatient, psychiatric unit or partial hospitalization;
- or
- Continuing Medical Education of at least 25 hours, acceptable to the department Chairman, prior to being granted privileges without further observation;
- and
- Demonstration of the provision of inpatient, outpatient or consultative services to at least 30 (10 for residents) patients in the past year.

Privileges included in the Child and Adolescent Core Privileges with observation requirements

☐ I request Child and Adolescent Core Privileges  ☐ I do not request Child and Adolescent Core Privileges

Privileges to admit, evaluate, diagnose, and provide non-surgical treatment to patients at or under the age of 17 who suffer from mental, behavioral or emotional disorders. Core privileges include, but are not limited to: psychiatric assessment, psychotherapy, and psychopharmacotherapy.

Observation requirements
First six (6) cases will be retrospectively reviewed.

Provisional year chart review requirement
All of the extension cases will be retrospectively reviewed, during the quality improvement process, during the first year at 6 and 12month intervals.

If there is not a sufficient level of activity during the provisional period, recommendations for privileges or an extension of provisional status will be at the discretion of the department Chairman.
**Special procedures privileges with observation requirements**

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges.

<table>
<thead>
<tr>
<th>Requested Procedure</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biofeedback</td>
<td>Credentials from the Biofeedback Certification Institute of America; or 30 hours Graduate course working; and Documentation of 3 treatment courses. Retropective review of first six (6) cases required.</td>
</tr>
<tr>
<td>ECT</td>
<td>Documentation of 3 treatment courses. Retropective review of first six (6) cases required.</td>
</tr>
<tr>
<td>Experimental Psychopharmacology</td>
<td>Documentation of 3 treatment courses of the same type or review of request by department Chairman; and Concurrent observation, number of cases to be determined by department Chairman.</td>
</tr>
<tr>
<td>Hypnotherapy</td>
<td>Successful completion of the advanced training from an APA accredited training program (i.e., Erickson Institute Programs, Society of Clinical and Experimental Hypnosis, American Society for Clinical Hypnosis); or 60 hours of Graduate course work; or Membership in the Society of Clinical and Experimental Hypnosis or the American Society for Clinical Hypnosis of the International Society of Hypnosis. Concurrent observation, number of cases to be determined by department Chairman.</td>
</tr>
<tr>
<td>Moderate Sedation</td>
<td>If requested, specific privileging guideline will be forwarded to you.</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>
Name:  

Acknowledgement of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at McLaren Greater Lansing, and

I understand that:
(a)  In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
(b)  Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: ____________________________  Date: ________________

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Department Report
I have reviewed the requested clinical privileges and supportive documentation for the above named applicant and:

(   ) Recommend as requested.
(   ) Recommend with modifications as noted below:
   Modifications: _____________________________________________________________________
   _____________________________________________________________________
   _____________________________________________________________________
(   ) Do not recommend

Signed: ____________________________  Date: ________________
   Chairman, Department of Psychiatry

Signed: ____________________________  Date: ________________
   Co-Chief of Professional Staff (for interim privileges only)

Action:
Credentials Committee  Date:______________
Executive Committee  Date:______________
Board of Trustees  Date:______________

Comments/Modifications Recommended: __________________________________________________
______________________________________________________________________