# *Regions Hospital*
# *Delineation of Privileges*
# *Psychiatry*

**Applicant's Name:**_____ _____

**Last** **First** **M** **Date**

**Instructions:** **Applicants must provide complete names and addresses for their references. <u>Please DO NOT SEND letters of recommendation along with your application</u>. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.**

## ☐ CORE I- General Privileges Psychiatry

| Privileges | Basic Education & Minimal Formal Training | Required Documentation and Experience |
|---|---|---|
| Privileges include being able to admit, work-up, diagnosis and provide treatment to patients above the age of 15 who suffer from mental, behavioral, or emotional disorders. Privileges include being able to provide consultation with physicians in other fields regarding mental, behavioral, or emotional disorders and their interaction with physical disorders. | 1. MD, DO, MBBS<br>~~2.~~ Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in Psychiatry. | <u>New Applicants:</u><br>1. Demonstration that the applicant has provided inpatient, outpatient or consultative services for at least 30 patients during the past 12 months, or<br>2. Names and addresses of two (2) physicians who we may contact who can comment on the applicant's current competency to perform the privileges requested.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____<br><br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____<br><br><u>Reappointment Applicants:</u><br>1. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____ |

## ☐ CORE II- General Privileges Child & Adolescent Psychiatry

| Privileges | Basic Education & Minimal Formal Training | Required Documentation and Experience |
|---|---|---|
| Privileges include being able to admit, work-up, diagnosis and provide treatment to children and adolescents who suffer from mental, behavioral, or emotional disorders. Privileges include being able to provide consultation with physicians in other fields regarding mental, behavioral, or emotional disorders and their interaction with physical disorders. | 1. MD, DO, MBBS<br>2. Successful completion of an ACGME or AOA, Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in Child & Adolescent Psychiatry. | New Applicants:<br>**1.** Demonstration that the applicant has provided inpatient, outpatient or consultative services for at least 30 patients during the past 12 months, **or**<br>2. Names and addresses of two (2) physicians whom we may contact who can comment on the applicant's current competency to perform the privileges requested.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____<br><br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____<br>Reappointment Applicants:<br>1. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____ |

## ☐ CORE III- General Non-Staff Privileges Psychiatry (designated for Moonlighters)

| Privileges | Basic Education & Minimal Formal Training | Required Documentation and Experience |
|---|---|---|
| Privileges include with appropriate consultation by a psychiatrist with Core I privileges, work-up, and diagnosis and provide treatment to patients above the age of 15 who suffer from mental, behavioral, or emotional disorders. Privileges include being able to provide consultation with physicians in other fields regarding mental, behavioral, or emotional disorders and their interaction with physical disorders. | 1. MD, DO, MBBS<br>2. Successful completion of an ACGME or AOA approved residency training program, or<br>3. Currently enrolled in an ACGME or AOA approved residency training program. | New Applicants:<br>1. Names and addresses of two (2) physicians who are not peers, whom we may contact who can comment on the applicant's current competency to perform the privileges requested.<br>Name: _____<br>Name of Facilty:_____<br>Add:_____<br>Ph/Fax: _____<br><br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____<br>Reappointment Applicants:<br>1. Evaluation of your competency conducted by a qualified staff physician peer. Please indicate name and address of the physician whom we may contact.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____ |

## ☐ CORE IV- Special Privileges Psychiatry

| Procedures | Basic Education & Minimal Formal Training | Required Documentation and Experience |
|---|---|---|
| ☐ Hypnosis<br><br>☐ ECT | 1. MD, DO, MBBS<br>~~2.~~ Successful completion of an ACGME or AOA Royal College of Physicians and Surgeons of Canada, or Professional Corporation of Physicians of Quebec approved residency training program in Psychiatry. | <u>New Applicants</u>:<br>1. Fulfillment of criteria for Core I Privileges in Psychiatry, and<br>2. Documentation of successful completion of a training program in the special procedure which includes administration of the procedure under staff supervision, or<br>3. Previous experience and training sufficient to demonstrate competency in administering the procedure/treatment.<br>4. Treatment includes the ability to: evaluate the patient for treatment need and suitability; follow the patient in the immediate post-treatment period; evaluate for completion of treatment; and does not include the administration of general anesthetic.<br><br><u>Reappointment Applicants:</u><br>1. Evaluation of your competency conducted by a qualified physician peer of your choice. Please indicate name and address of the physician whom we may contact.<br>Name: _____<br>Name of Facility:_____<br>Add:_____<br>Ph/Fax: _____ |

**TO BE COMPLETED BY APPLICANT:**

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

_____ _____

Signature Date

**TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:**

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Signature Date