

LICENSED MENTAL HEALTH PROFESSIONALS
 (Clinical Social Worker, Mental Health Counselor, Marriage & Family Therapist)
PRIVILEGE FORM

NAME: _____ EFFECTIVE DATE: _____ To _____

LEGEND: 1 – BMC - Jax 2 – BMC - Beaches 3 – BMC - Nassau 4 – SV Southside 5 – SV Riverside
 6 – Shands Jax/SJ TCU 7 – Wolfson 8 – Brooks 9 – BMC - South 10 – SV Clay

The minimum education, training and experience qualifications for core privileges are as delineated in each hospital's Medical Staff Bylaws, Rules and Regulations, or policies. Please consult these documents to determine your eligibility to request these privileges.

To request Core Privileges, please place an "X" in the appropriate hospital column.

1	2	3	4	5	6	7	8	9	10	CORE PRIVILEGES	APPR
										Children: Psychotherapy (family, group, individual)	
										Adolescents: Psychotherapy (family, group, individual)	
										Adults: Psychotherapy (family, group, individual)	
										Record psychosocial assessment and progress notes	

To request Special Procedures, please place an "X" in the appropriate hospital column. If the condition/privilege you desire is not included on this form, please submit a separate written request for the privilege along with documentation of training and/or experience.

1	2	3	4	5	6	7	8	9	10	SPECIAL PROCEDURES Procedures that are not routinely part of training, and may require proof of training or experience.	APPR
										Participate in Discharge Planning	
										Biofeedback [++Hospitals 1, 4, 5, 10]	
										Hypnosis [++Hospitals 2]	

Acknowledgment of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by each hospital's Medical Staff policies, rules and regulations, and (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of each hospital's Medical Staff Bylaws.

Applicant Signature: _____ *Date:* _____

Acknowledgment of Supervising Physician: The above named practitioner shall be under my supervision in the exercise of clinical privileges. I acknowledge that above named practitioner is competent and qualified to perform the requested privileges.

Supervising Physician Signature: _____ *Date:* _____

■ Privilege not available in this specialty at this hospital.
 ++ Please refer to this hospital's Bylaws or Rules and Regulations regarding specific criteria to be met before this privilege may be granted.