Loma Linda University Behavioral Medicine Center
Loma Linda, CA 92354

PRACTICE PRIVILEGE REQUEST FORM

CLINICAL AREA: MARRIAGE, FAMILY, THERAPIST

Name:____ Page 1 of 2

CATEGORY	QUALIFICATIONS
All	1. Masters Degree in Marriage and Family Counseling from an accredited university. 2. Current California State MFT license issued by the Behavioral Science-Examiners. 3. Meets Bylaw requirements for Allied Health Professionals. 4. Proctoring of 100% of patients up the three (3) within the provisional privilege period.
Individual Psychotherapy	Documented training and/or supervised experience in the theory and practice of individual therapy/counseling.
Group Psychotherapy	Documented training and/or supervised experience in theory and practice of group therapy.
Family/Couple/Marital Psychotherapy	Documented training and/or supervised experience in the theory and practice of family/couple/marital therapy.
Chemical Dependency Counseling	Documented graduate course work in theory/techniques of chemical dependency counseling, inpatient hospital experience or documented concurrent work experience in a chemical dependency program.
Biofeedback	Certification and/or documented training and experience in a specialty area.

REQUESTED		CODE	PRACTICE PRIVILEGES	ACTION		
YES	NO			Approved	Conditions	Denied
			Provide patient care services independently within the scope of my license and privileges, as ordered by the attending physician.			
			Individual psychotherapy			
			Adult			
			Adolescent			
			Child			
			Group Psychotherapy			
			Adult			
			Adolescent			
			Child			
			Family/Couple/Marital Psychotherapy			
			Chemical Dependency Counseling			
			Biofeedback			

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Acknowledgment of Practitioner

I have requested only those specific practice privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Loma Linda University Behavioral Medicine Center; **and**

I understand that:

(a) In exercising any practice privileges granted, I am constrained by any hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the practice privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

Signed: ____________________________ Date: ________________________

******* For Hospital and/or Clinic Use Only *******

Conditions/Modifications:
The requested practice privileges have been approved by the Board of Trustees with the following conditions, modifications and the explanation for same.

Code	Privilege	Condition/Modification
Code	**Explanation:**	

__________________________________ _______________
Discipline Director Date

__________________________________ _______________
Supervising Physician Date

__________________________________ _______________
Medical Director Date

__________________________________ _______________
Credentials Committee Date

__________________________________ _______________
Medical Staff Executive Committee Date

__________________________________ _______________
Governing Board Designee Date

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