GULF COAST MEDICAL CENTER
Delineation of Privileges for Allied Health Professional
Psychology

Name: ________________________ Physician Sponsor(s)/Contract: ____________________________.
License Number(s): ______________ Certification/Re-certification Number: ______________________.

PRIVILEGE	Currently Approved	Requested	Approved
GENERAL:			
Provide Mental Health Consultations			
Provide Mental Health Evaluations			
Provide Individual Psychotherapy			
Provide Group Psychotherapy			
Provide Component Psychotherapy			
Provide Psychological Testing			
Write Orders / Progress Notes in Patient Charts			
Order Diagnostic / Therapeutic Services			
OTHERS:			

Comments / Modifications: ____
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I hereby request that I be allowed to perform the privileges requested, as delineated above that are checked above, under the supervision of my sponsoring physician(s) and attest that I have current competence to perform each of them.

______________________________________ ____________________________.
Applicant Date

I/We, the sponsoring physician(s) hereby affirm that this individual is sufficiently competent to perform the privileges requested.

______________________________________ ____________________________.
Signature of Sponsoring Physician Date

______________________________________ ____________________________.
Signature of Sponsoring Physician Date

______________________________________ ____________________________.
Signature of Sponsoring Physician Date

______________________________________ ____________________________.
Signature of Sponsoring Physician Date

______________________________________ ____________________________.
Signature of Department Chairperson Date

______________________________________ ____________________________.
Credentials Approval Date

______________________________________ ____________________________.
Medical Executive Approval Date

______________________________________ ____________________________.
Board of Trustees Approval Date