

UNIVERSITY OF MARYLAND MEDICAL CENTER

DEPARTMENT OF NEUROLOGY/REHABILITATION MEDICINE

REQUEST FOR CLINICAL PRIVILEGES

APPLICANT'S NAME: _____

DATE: _____

REQUESTED PRIVILEGES	CHECK IF REQUESTED	CHAIR APPROVAL Initial if Yes, Write Not Approved if No
Electromyography		
Nerve conduction studies		
Nerve Block		
Intraarticular Injection		
Intraarticular Aspiration		
Soft Tissue Injection		
Limb Prosthetic Prescription		
Orthotic Prescription		
Lumbar Puncture		
Other		

Applicant's Signature

Date

William J. Weiner, MD
Chairman, Department of Neurology

Date

Applicant's Confirming Signature
(to be completed if any requested privilege is not approved)

Date