UNIVERSITY OF MARYLAND MEDICAL CENTER
Department of Psychiatry
Delineation of Privilege Form

Applicants for membership in the Department of Psychiatry of the University of Maryland Medical Center may request admission to the Active staff or the Courtesy staff.

Please indicate the Staff Category to which you wish to apply: *(refer to Medical Staff Bylaws for qualifications)*

_____ Active _____ Courtesy

Name: _____ Date: _____
Clinical Division:_____ ___ _____ ____
Practice Sites: ___ UMMC ___ VA ___ MPRC ___ WPCC ___ PA ___ USH ___ Other _____

NOTE: Privileges marked with an asterisk (*) also require approval of Moderate Sedation privilege (under Section 4)

Privilege/Operative Procedure	**Check (√) if Requested**	**Chair Approval Initial if Yes Write Not Approved if No**
Category 0: In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff status, service or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. ***Approved per the Medical Staff Bylaws***	√*	**Yes**
Category I – To be eligible for Category I privileges, applicants must have completed an ACGME approved General Psychiatry residency and be Board Certified or a Candidate for Board Certification. **Category I privileges include: assessment and diagnosis, treatment planning and therapeutic techniques including behavioral and cognitive therapy, individual, group, couples & family therapy, and psychopharmacology as well as psychosocial rehabilitation for patients of various ages and diagnoses.**		
Category II – To be eligible for Category II privileges, applicants must complete the requirements for Category I and must have completed a post-residency fellowship or board, added qualification and/or other certificate (attach certificate(s)). **While psychiatrists may see patients of various ages and diagnoses, the below recognizes areas of special competence and usually indicate a major commitment to patients or practice in this area.**		
Subspecialties recognized by the ABPN and ABMS:		
Child & Adolescent Psychiatry		
Geriatric Psychiatry		
Addiction Psychiatry		
Forensic Psychiatry		
Subspecialties not recognized by the ABPN or ABMS, but with certification processes:		
Administrative Psychiatry		
Psychoanalysis		
Consultation/Liaison Psychiatry		

Name: _____ DATE: _____

NOTE: Privileges marked with an asterisk (*) also require approval of Moderate Sedation privilege (under Section 4)

Privilege/Operative Procedure	**Check (√) if Requested**	**Chair Approval Initial if Yes, Write Not Approved if No**
Category III – To be eligible for Category III privileges, applicants must have completed an ACGME approved General Psychiatry residency, be Board Certified or a Candidate for Board Certification, and have additional training and/or experience. Complete attached documentation sheet for each specialized procedure/practice requested.		
Specialized Procedures:		
Biofeedback		
Electroconvulsive Therapy		
Hypnosis		
Sexual Therapy		
Sodium Amytal Interview *		
Other: _____		
_____		
Specialized Practice:		
Child & Adolescent Psychiatry		
Geriatric Psychiatry		
Addiction Psychiatry		
Category IV: Special/Cross Disciplinary Procedures:		
Moderate (Conscious) Sedation - Criteria for Approval: 1. Proof of Current BCLS certification (please attach); 2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment). *(Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral & Maxillofacial Surgery are not required to fulfill criteria)*		

_____ _____
Applicant's Signature Date

_____ _____
Medical Supervisor Date

I attest that in making this appointment, due consideration has been given to the applicant's professional performance, judgement and technical skill prior to the appointment period. I have not observed or been informed of conduct indicating a present or potential health problem that affects the applicant's ability to perform clinically or to fulfill staff obligations.

_____ _____
Bankole Johnson, MD
Chairman, Department of Psychiatry Date

_____ _____
Applicant's Confirming Signature Date
(required if any requested privilege is not approved)

Revised 7/04

UNIVERSITY OF MARYLAND MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY

Documentation of Application for Specialized Procedures/Practices in Psychiatry

NAME:_____ **DATE:** _____

Nature of Specialized Procedure/Practice: (Complete one for each procedure/practice requested. Use additional paper if needed.)

1. Describe all didactic/clinical training received in this specialty area:

2. List supervised experiences you have had:

3. Have you ever been named in any malpractice action or had your clinical privileges limited, suspended or revoked while working in this specialty area, or utilizing this specialized procedure. (If YES, please explain)

4. Provide name, address and telephone number of a professional who can attest to your expertise in this specialty. Upon completion of this form, have this individual sign in support of your application. Note that this individual should be a recognized authority themselves in this specialty or a previous supervisor with significant knowledge of your expertise.

_____
Name (Please PRINT or TYPE)

_____
Address

_____

_____
Signature **Date**

I attest to the accuracy of the information provided above:

_____ _____
Signature of Applying Psychiatrist **Date**

UNIVERSITY OF MARYLAND MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY

Documentation of Application for Specialized Procedures/Practices in Psychiatry

NAME:_____ **DATE:** _____

1. Describe your practice activity (site, volume of service, age and diagnostic diversity, therapeutic techniques used, etc.) For each practice are requested:

   A. General

   B. Subspecialty

   C. Specialized Procedures (biofeedback, hypnosis, ETC, etc.)

   D. Specialized Practice (child, geriatric, addiction, etc.)

2. List all continuing education activities since the last application for privileging that support the current requested clinical privileges (include dates, topic and credits obtained).

3. Have you obtained any additional licenses or certifications (list date obtained and details).

I attest to the accuracy of the information provided above:

_____ _____
Signature of Applying Provider **Date**

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4. Utilization Review, Risk & Quality Management and Peer Review Information was evaluated in the re-credentialing process.

   _____YES _____NO