

#### OUTPATIENT MENTAL HEALTH CLINICAL PRIVILEGES

Prospective consultants will receive consideration without discrimination because of race, creed, color, gender, age, national origin, handicap or veteran status.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License\_\_\_\_\_\_\_\_\_\_\_\_

 Last First  **(LGSW, LCPC, MD, etc.)**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Telephone #: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Native language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever applied for a position with our agency?

\_\_\_Yes \_\_\_No If yes, state month, year and location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State names of relatives and friends working for us, including spouse (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When will you be able to begin work? \_\_\_\_\_\_\_\_\_\_ Seeking a full time or contractual position: \_\_\_\_\_

Other special training or skills (languages, computer skills, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Membership in Professional or Civic Organizations (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Licenses obtained (state, license and number and provide a copy to Human Resources:

Are you a member of the Armed Forces? If so what Branch?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you First Aid and CPR certified? (list type and expiration date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a U.S. Citizen? \_\_\_\_\_ Yes \_\_\_\_\_ No

**EDUCATION HISTORY:**

**HIGH SCHOOL:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of School City/State**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Years of Attendance Degree Obtained**

**COLLEGE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of School City/State**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Years of Attendance Degree Obtained**

**GRADUATE SCHOOL:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of School City/State**

**From\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Years of Attendance Degree Obtained**

**EMPLOYMENT HISTORY:** *Please give accurate, complete full-time and part-time employment record. Start with your present or most recent employer***. A copy of your current resume must be submitted to Human Resources.**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Company Name Telephone***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed – (State month and year)

 ***Address From \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Job Title Name of Supervisor***

 Briefly describe your duties: Reason For Leaving:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Company Name Telephone***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed – (State month and year)

 ***Address From \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Job Title Name of Supervisor***

 Briefly describe your duties: Reason For Leaving:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Company Name Telephone***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed – (State month and year)

 ***Address From \_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Job Title Name of Supervisor***

 Briefly describe your duties: Reason For Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any skills, experience or achievements obtained that will assist you with the position in which you are seeking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### PROFESSIONAL ATTAINMENTS

1. Please provide the information in this section either in an up-to-date curriculum vitae/resume or on plain paper with your name on each page. To help the committee locate information in your attachments, please indicate the type of attachment that contains this information.

See Attached See Attached N/A or

Vitae/Resume List None

1. Educational preparation,

including all post-secondary

degrees and experiences \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. History of relevant work

experience, listing all

previous jobs related to

your profession \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Internships/Fellowships/

Assistantships \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Research/Evaluation

activities \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 5. Publications/Presentations \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 6. Honors/Awards/Citations \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Membership in professional

organizations \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Membership in other

clinical or professional

staff \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 9. Offices held \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Professional committee

assignments \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 11. Board Certification \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Teaching/Faculty

appointments elsewhere \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Other professional

attainments \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

1. Names and telephone numbers of three Mental Health Professionals who can attest to your professional competence and ethical character. If possible, include two peers from a clinical professional staff.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone

 **C.** Privileges Elsewhere: List previous and current privileges at other health care organizations, including dates and granting organizations. Check here \_\_\_\_\_\_\_ if supplemental list is attached.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

CREDENTIAL REQUIREMENTS

 Please provide current information for the following:

A. State of Maryland License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_\_

B. District of Columbia License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_\_ Exp: \_\_\_\_\_\_\_\_\_\_

C. Other State License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_\_

Exp: \_\_\_\_\_\_\_\_\_\_

D. Federal DEA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_\_

Exp: \_\_\_\_\_\_\_\_\_\_

E. State DEA #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Issued: \_\_\_\_\_\_\_\_\_

Exp: \_\_\_\_\_\_\_\_\_\_

F. Professional Liability Ins. Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Issued: \_\_\_\_\_\_\_\_\_\_

Exp: \_\_\_\_\_\_\_\_\_\_

**ADVERSE EXPERIENCES**

**(If you answer YES to any question below, attach a description and explanation of the circumstances.)**

1. Are you now or have you been involved in administrative professional or judicial proceedings in which professional malpractice on your part is or was alleged

**Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

 **B.** Have there been any final judgments against you in a malpractice case?

#  Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

1. Have you ever lost or relinquished malpractice insurance?

#  Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

1. Have you ever been denied membership, or been subjected to disciplinary proceedings by any medical or professional staff or professional organization? **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

 **D.** Have you ever voluntarily relinquished membership in a professional organization?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

 **E.** Have you ever been fired from any professional job for any reason?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

 **F.** Have you ever quit a job upon being notified you might be fired?

 **Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

**G.** Have your privileges at any hospital or mental health facility ever been denied, diminished, limited, suspended, revoked, or not renewed?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

1. Have you ever voluntarily relinquished or limited your privileges?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

1. Has your license/certification/registration to practice ever been denied, limited, suspended, or revoked in any jurisdiction?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

1. Have you ever voluntarily limited or relinquished your licensed/certification/registration to practice in any jurisdiction? **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**
2. Have you ever been convicted of a misdemeanor or felony?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

1. Have you ever been convicted of any violation of law pertaining to your profession?

 **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

1. Have there ever been any investigations of your activities by a licensing board, hospital, mental health facility, or professional organization? **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**
2. Have there been any other adverse experiences, which might negatively effect your eligibility for medical staff membership or clinical privileges? **Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_**

STATE OF HEALTH

**Each applicant MUST answer ONE of the following:**

\_\_\_\_\_ I certify that I am in good health and have no physical or mental limitations that may adversely impair my ability to render quality patient care or appropriate services for clients.

\_\_\_\_\_ I do have physical and/or mental limitation(s) to my health but believe that this does not significantly impair my ability to render quality patient care or appropriate services for clients. *(Please provide a full explanation including the name and address of your personal physician on a separate sheet.)*

DELINEATION OF PRIVILEGES FOR OUTPATIENT/CLINCIAL SERVICES

**Select your discipline:**

□ Social Worker □ Psychiatrist □ R.N. □ Psychologist □ Professional Counselor

□ Marriage & Family Therapist □ Alcohol & Drug Counselor □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select the privileges you are requesting:**

Please **only** check the box next to each privilege for which you are requesting to be privileged to provide services. STS’ authorized staff will determine if the privileges requested are approved or denied and they will sign where indicated. By signing below the authorized staff of STS is either approving or denying the requested privileges based on your experience and licensure. For more information regarding the privileging process, please see either the HR Director, OMHC Program Director or the Clinical Supervisor.

 **Privilege**  **Approval or Denial** **Signature**

□ Psychosocial Assessment (Child & Adolescent) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Psychosocial Assessment (Adults) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Individual Psychotherapy (Child & Adolescent) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Individual Psychotherapy (Adults) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Group Psychotherapy (Child & Adolescent) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Group Psychotherapy (Adults) □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Psycho-educational Group □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (specify subject matter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Family Psychotherapy □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Couples Psychotherapy □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Determining DSM-IV Diagnosis □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Development and implementation of □ Approved

 treatment plans □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Clinical Supervision □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Case Management □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Medication Management □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Psychiatric Evaluation □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Therapeutic Injections □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Educational achievement testing □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Psychological testing □ Approved

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Approved □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Approved □ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Denied

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are seeking **limited** privileges in any of the above disciplines, please list limitations:

|  |
| --- |
|  |
|  |

Within the discipline(s) checked, I am further qualified by training and/or experience to perform the following special procedures and/or to receive privileges in the following areas of special competence (ex: Sign Language):

|  |
| --- |
|  |
|  |
|  |
|  |

##### STATEMENT OF APPLICATION

I have received the information about the Independent Contractor and I agree to be bound by the terms thereof if granted privileges and to be bound by the terms thereof without regard to whether or not I am granted privileges in all matters relating to consideration to this application.

In making application for appointment to the SFS, Inc. clinical staff, I agree to abide by such rules and regulations as it may from time to time enact.

I hereby authorize SFS and their representatives to consult with other institutions with which I have been associated and with others, including past and present professional liability carriers, who may have information bearing upon my professional competence, character and ethical qualifications.

I hereby release from liability all representatives of SFS, Inc. for their act performed in good faith and without malice in connection with the evaluation of my application and my credentials and qualifications; and I hereby release from any liability any and all individuals and organizations who provide information to SFS, Inc. in good faith and without malice concerning my professional competence, character and other qualifications for appointment and privileges, and I hereby consent to the release of such information.

I hereby authorize SFS, Inc. to communicate to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics which SFS, Inc. may have or acquired; and where such communication is made in good faith and without malice, I consent thereto and agree to hold SFS, Inc. and its authorized representatives free of liability thereof.

I acknowledge my obligation to provide continuous care and supervision to my clients, I further agree to subject my performance to, and faithfully participate in SFS, Inc.’s Quality Improvement Programs as the same shall from time to time be in effect in accordance with the requirements of the Department of Health and Mental Hygiene and as required by the Code of Maryland Regulations (COMAR) as well as any other relative jurisdictional authorities. I agree to hold members of the Staff and other authorized representatives of SFS, Inc. in these quality improvement activities free from all liability for their actions performed in good faith in connection therewith.

The information provided in this application is true, correct, and complete. If considered, any misstatement or omission of fact on this application may result in my dismissal.

I understand the acceptance of an offer, as a consultant does not create a contractual obligation upon SFS to continue to use me as a consultant in the future.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signature