UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

☐ Initial Appointment
☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: 4/3/2013.

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR GENERAL PSYCHIATRY

To be eligible to apply for core privileges in general psychiatry, the initial applicant must meet the following criteria:

Current specialty certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

OR

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in psychiatry and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to specialty certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate the provision of a sufficient volume of inpatient, outpatient, or consultative services, reflective of the scope of privileges requested, in the past 24 months, or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

Reappointment Requirements: To be eligible to renew core privileges in general psychiatry, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience, with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. (Volume may include patients who are part of a research protocol.) Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. Medical Staff members whose board certificates is psychiatry bear an expiration date shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

CORE PRIVILEGES

GENERAL PSYCHIATRY CORE PRIVILEGES

☐ **Requested** Admit, evaluate, diagnose, treat and provide consultation to patients of all ages, presenting with mental, behavioral, addictive or emotional disorders, e.g., psychoses, depression, anxiety disorders, substance abuse disorders, developmental disabilities, sexual dysfunctions, and adjustment disorders. Includes general medical management of patients concurrent with psychiatry privileges. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Privileges include:

- Consultation with physicians in other fields regarding mental, behavioral or emotional disorders
- Pharmacotherapy
- Psychotherapy
- Family therapy
- Behavior modification
- Consultation to the courts
- Emergency psychiatry
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Performance of a history and physical exam
- Telehealth

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

QUALIFICATIONS FOR CHILD AND ADOLESCENT PSYCHIATRY

To be eligible to apply for core privileges in child and adolescent psychiatry, the initial applicant must meet the following criteria:

As for General Psychiatry plus successful completion of an accredited ACGME or AOA fellowship in child and adolescent psychiatry.

AND

Current subspecialty certification or active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to subspecialty certification in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or Certificate of Special Qualifications in child and adolescent psychiatry by the American Osteopathic Board of Neurology and Psychiatry.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate the provision of a sufficient volume of inpatient, outpatient, or consultative services to child or adolescent patients, reflective of the scope of privileges requested, during the past 24 months, or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Reappointment Requirements: To be eligible to renew core privileges in child and adolescent psychiatry, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and a sufficient volume of experience treating child or adolescent patients, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. (Volume may include patients who are part of a research protocol.) Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. Medical Staff members whose board certificates bear an expiration date shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

CORE PRIVILEGES

CHILD AND ADOLESCENT PSYCHIATRY CORE PRIVILEGES

☐ **Requested** Admit, evaluate, diagnose, treat, and provide consultation to children and adolescents, who suffer from mental, behavioral, addictive or emotional disorders. Privileges include general medical management of patients concurrent with psychiatry privileges, and performance of history and physical exam. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Privileges include:

- Consultation with physicians in other fields regarding mental, behavioral or emotional disorders
- Pharmacotherapy
- Psychotherapy
- Family therapy
- Behavior modification
- Consultation to the courts
- Consultation to schools
- Emergency psychiatry
- Performance of a history and physical exam
- Order respiratory services
- Order rehab services
- Telehealth

CHECK HERE TO REQUEST NEUROLOGY PRIVILEGES FORM.

☐ **Requested**

CHECK HERE TO REQUEST SLEEP MEDICINE PRIVILEGES FORM.

☐ **Requested**

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, Non-Core Privileges are requested individually in addition to requesting the Core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

HYPNOTHERAPY

☐ **Requested**

Criteria: Evidence of satisfactory completion of training in an accredited program such as a psychiatric residency training program at a University or one sponsored by an appropriate organization such as the American Psychiatric Association or the American Psychological Association; and evidence of satisfactory completion of training in the practice of hypnosis under the supervision of a person qualified for hypnosis; and evidence of continuing education and/or supervision in hypnosis by significant attendance at courses and/or publishing articles in journals or books of good standing during the past five years. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of hypnotherapy procedures in the past 24 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of hypnotherapy procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

ELECTROCONVULSIVE THERAPY (ECT)

☐ **Requested**

Required Previous Experience: Demonstrated current competence and evidence of the provision of ECT treatments to a sufficient volume of different patients during the past 24 months. Treatment must have included the evaluation of the patient for treatment need and suitability, immediate post treatment follow-up and evaluation at completion of the treatment course OR provision of ECT treatments to a sufficient volume of different patients at UHHS under the supervision of a physician who has been granted the privilege. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the provision of ECT treatments to a sufficient volume of different patients during the past 24 months based on results of ongoing professional practice evaluation and outcomes.

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

LUMBAR PUNCTURE

☐ **Requested**

Criteria: Successful completion of an ACGME or AOA accredited residency in psychiatry which included training in lumbar puncture, or evidence of active clinical practice in the procedure. ***Required Previous Experience***: Demonstrated current competence and evidence of the performance of a sufficient volume of lumbar punctures in the past 24 months. ***Maintenance of Privilege***: Demonstrated current competence and evidence of the performance of a sufficient volume of lumbar punctures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at University Hospital and Health System, University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical 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 or related documents.

Signed_____ ***Date***_____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

_____

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_____

Division Chief Signature_____ ***Date***_____

PSYCHIATRY CLINICAL PRIVILEGES

Name: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

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Department Chair Signature_____ ***Date***_____

Revisions:

03/10, 6/2/2010, 10/5/2011, 12/16/2011, 1/4/2012, 11/07/2012, 4/3/2013