# Loma Linda University Behavioral Medicine Center
**Loma Linda, CA 92354**

**PRIVILEGE FORM**

CLINICAL AREA: LICENSED CLINICAL SOCIAL WORKER 

Name:_____

| CATEGORY | QUALIFICATIONS |
|---|---|
| All | 1. Masters Degree in Social Work from an accredited graduate school of Social Work.<br>2. Current California State LCSW license issued by the Behavioral Science-Examiners.<br>3. Meets Bylaw requirements for Allied Health Professionals.<br>4. Proctoring of 100% of patients - up to three (3) within the provisional privilege period. |
| Individual Psychotherapy | Documented training and/or supervised experience in the theory and practice of individual therapy/counseling. |
| Group Psychotherapy | Documented training and/or supervised experience in theory and practice of group therapy. |
| Family/Couple Psychotherapy | Documented training and/or supervised experience in the theory and practice of family/couple/marital therapy. |
| Chemical Dependency Counseling | Documented graduate course work in theory/techniques of chemical dependency counseling, inpatient hospital experience or documented concurrent work experience in a chemical dependency program. |
| Biofeedback | Certification and/or documented training and experience in a specialty area. |

| PRIVILEGE | | ACTION | | |
|---|---|---|---|---|
| Requested | | Approved | Conditions | Comment |
| | NO | | | |
| | Individual psychotherapy | | | |
| | Adult | | | |
| | Adolescent | | | |
| | Child | | | |
| | Group Psychotherapy | | | |
| | Adult | | | |
| | Adolescent | | | |
| | Child | | | |
| | Family/Couple Psychotherapy | | | |
| | Chemical Dependency Counseling | | | |
| | Biofeedback | | | |


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Name:_____

**Acknowledgment of Practitioner**

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at Loma Linda University Behavioral Medicine Center; **and**

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any 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.

Signed: _____Date: _____

******* For Hospital and/or Clinic Use Only *******

**Conditions/Modifications:**

The requested clinical privileges have been approved by the Governing Body with the following conditions, modifications and the explanation for same.

| Code | Privilege | Condition/Modification | Explanation/Comment |
|---|---|---|---|
| | | | |
| | | | |

_____ _____

Discipline Director Date

_____ _____

Supervising Physician Date

_____ _____

Credentials Committee Date

_____ _____

Medical Staff Executive Committee Date

APPROVED:

_____ _____

Governing Body Officer Date


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