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Applicant Name

**St. Elizabeth Healthcare**  
**Psychiatry**

**Minimum Requirements**

Degree required: MD or DO

Successful completion of ACGME or AOA approved residency training program in psychiatry

**Note:** Members who first apply for membership after March 2, 2009 must be and remain (with a lapse of no longer than one year) board certified in neurology/psychiatry, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. Only those boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are acceptable. This board certification requirement does not apply to applicants who on March 2, 2009 were members in good standing on the medical staff of the St. Luke Hospitals or St. Elizabeth Medical Center.

**Privileges Requested**

**I. Core Privileges:** Core privileges in psychiatry include the care, treatment or services listed immediately below. I specifically acknowledge that board certification alone does not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are not requesting.

**Request**

**Description of Privilege**

\_\_\_\_\_

Admit patients, perform histories and physicals and evaluate, treat and consult on psychiatric disorders as defined in the current Diagnostic and Statistical Manual of Mental Disorders, including the ordering of laboratory tests and treatment of non-critical medical problems; psychopharmacotherapy; individual, group and family therapy.

**II. Additional Privileges:** In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must meet all "Additional Requirements" listed for each privilege below and provide documentation (fellowship completion, training course certification, letter from program director or department chair at primary hospital, etc.) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or

persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

**Request**

**Description of Privilege**

\_\_\_\_\_ Electroconvulsive treatment with the assistance of hospital  
anesthesia staff

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Printed Name

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\_\_\_\_\_ Approved

\_\_\_\_\_ Disapproved

\_\_\_\_\_  
Chair, Section of \_\_\_\_\_

Date:

Remarks: