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

**PRIVILEGE FORM**

**CLINICAL AREA:** LICENSED CLINICAL SOCIAL WORKER  
Page 1 of 2

**Name:** __________________________________________________________

---

**CATEGORY** | **QUALIFICATIONS**
--- | ---

**All**  
3. Meets Bylaw requirements for Allied Health Professionals.  
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.

---

**REQUESTED** | **CODE** | **PRIVILEGE** | **ACTION**
--- | --- | --- | ---

**YES** | **NO** | **APPROVED** | **CONDITIONS** | **COMMENT**

Provide patient care services independently within the scope of my license and privileges, as ordered by the attending physician.

**Individual psychotherapy**

- **Adult**
- **Adolescent**
- **Child**

**Group Psychotherapy**

- **Adult**
- **Adolescent**
- **Child**

**Family/Couple Psychotherapy**

- **Chemical Dependency Counseling**
- **Biofeedback**
**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Privilege</th>
<th>Condition/Modification</th>
<th>Explanation/Comment</th>
</tr>
</thead>
</table>

Discipline Director  
Supervising Physician  
Medical Director  
Credentials Committee  
Medical Staff Executive Committee  
APPROVED:  
Governing Body Officer  

---

S:\MEDSTAFF\BMC\PRIVSHTS\bmc-lcsw.doc  
Revised: 11/08 7/99 7/01 8-01 3-11-03 8-6-04  
© Loma Linda Behavioral Medicine Center