<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>QUALIFICATIONS</th>
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</table>
| All                                          | 1. License as a Ph.D. or Psy.D. in the State of California (or the equivalent).  
2. One (1) year postgraduate (Ph.D.) hospital experience (psychiatric inpatient). |
| Child Psychotherapy                          | One (1) year experience with children in psychiatric inpatient or outpatient setting; or Certification and/or training program in child psychotherapy. |
| Adolescent Psychotherapy                     | One (1) year experience with adolescents in psychiatric inpatient or outpatient setting; or Certification and/or training program in adolescent psychotherapy. |
| Adult Psychotherapy                          | One (1) year experience with adults in psychiatric inpatient or outpatient setting; or Certification and/or training program in adult psychotherapy.       |
| Group Therapy                                | Concurrent experience and clinical supervision in the provision of psychotherapy to groups for a minimum of one (1) year.                                    |
| Individual Therapy                           | Concurrent experience and clinical supervision in the provision of psychotherapy to individuals for a minimum of one (1) year.                              |
| Chemical Dependency Counseling               | Alcohol Counseling Certification, (supply copy of certificate); or Thirty (30) CEU’s in Substance Abuse Counseling; or One (1) year experience working in substance abuse in an inpatient/outpatient psychiatric setting. |
| Family/Marital Therapy                        | One (1) year experience working in family therapy in inpatient/outpatient setting.                                                                          |
| Psychological Testing/Evaluation (includes educational evaluations) | At least one course in mental retardation, learning disabilities, or school psychology (for Child/Adolescent privileges); or One (1) year course work and one (1) year of documented supervised experience. | |
| Neuropsychological Testing/Evaluation         | Privileged at the hospital for Psychological Testing/Evaluation; and At least one (1) course in Neuropsychological theory and assessment; or Documentation of supervised experience in the administration, scoring, and interpretation of Neuropsychological tests. |
| Biofeedback                                   | Documentation from the Biofeedback Society of America or the Biofeedback Society of California; or Concurrent proctoring by a BCIA certified therapist. (This status can be used for a maximum of two (2) years). |
**PRIVILEGE FORM**

**CLINICAL AREA:** LICENSED PSYCHOLOGISTS

<table>
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<tr>
<th>REQUESTED</th>
<th>CODE</th>
<th>PRACTICE PRIVILEGES</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
<td>Approved</td>
</tr>
</tbody>
</table>

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

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

- **Group Therapy**
  - Child
  - Adolescent
  - Adult

- **Individual Therapy**
  - Child
  - Adolescent
  - Adult

- **Chemical Dependency**
  - Child
  - Adolescent
  - Adult

- **Family/Marital Therapy**
  - Child
  - Adolescent
  - Adult

- **Psychological Testing (includes educational evaluations)**
  - Child
  - Adolescent
  - Adult

- **Neuropsychological Testing**
  - Child
  - Adolescent
  - Adult

- **Biofeedback**
  - Child
  - Adolescent
  - Adult
Loma Linda University Behavioral Medicine Center
Loma Linda, CA 92354

PRIVILEGE FORM

CLINICAL AREA: LICENSED PSYCHOLOGISTS

Name:_____________________________________________________                    Page 3 of 3

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 practice 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 practice 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 practice privileges have been approved by the Board of Trustees with the following
conditions, modifications and the explanation for same.

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

Code Explanation:

Discipline Director

Supervising Physician

Medical Director

Credentials Committee

Medical Staff Executive Committee

Governing Board Officer

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CLINICAL AREA: LICENSED PSYCHOLOGISTS

Name:_____________________________________________________

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