Practitioner Name: 

Practice Specialty Requested: 

<table>
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<tr>
<th>REQUESTED</th>
<th>PRACTICE PRIVILEGE REQUESTED</th>
<th>ACTION</th>
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**GENERAL PRIVILEGES**

- Write requests for tests, therapy, consults, transfers, and discharges
- Consults in area of competence

**DISCIPLINE SPECIFIC PRIVILEGES**

- Mental retardation
- Organic Brain Syndrome
- Psychoses
- Neuroses
- Personality Disorders
- Psychophysiologic Disorders
- Special Symptoms
- Transient Situational Disturbances
- Behavioral Disorders of Childhood and Adolescence
- Diagnostic Psychological Testing
- Psychoanalytic Psychotherapy
- Behavioral Therapy
- Gestalt Therapy
- Group Therapy
- Crisis Evaluation and Therapy
- Conjoint Therapy
- Marital Therapy
- Sex Therapy
- Family Therapy
- Geriatric Therapy (65+ years age)
- Adolescent Therapy (14-18 years age)
- Play Therapy
- Biofeedback

Acknowledgment of AHP

In accordance with the provisions of Section 3055 of the Business and Professions Code, I am licensed as a Clinical Psychologist in the State of California and subject to the Laws and the rules and regulations of the California licensing agency. I acknowledge that I have received a copy of the Medical Staff Bylaws and Rules and Regulations, and agree to be bound by the terms of the Bylaws and Policies of the Medical Staff and of the hospital and all other manuals and policies relevant to practice privileges at Loma Linda University Medical Center under the AHP category.

I have requested only those specific practice privileges for which by education, training, current experience and demonstrated performance for which I am qualified and wish to exercise at Loma Linda University Medical Center, Inc.; and I understand that 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.

Applicant Signature ___________________________ Date ___________________________
Loma Linda University Medical Center
Clinical Psychologist Practice Privilege Form
Page 2

Applicant Name________________________________________

Practice Specialty_______________________________________

_____________________________________________________
Supervising Physician Signature                        Date

_____________________________________________________
Discipline Director                                      Date

_____________________________________________________
Service Chief Signature                                  Date

_____________________________________________________
Credentials Committee Chair                              Date

_____________________________________________________
Medical Staff Executive Committee Chair                  Date

_____________________________________________________
Governing Board Officer/Designee                        Date