Huntington Memorial Hospital

Delineation Of Privileges

Marriage & Family Therapist Privileges

Provider Name:

Privilege	Requested	Deferred	Approved

CORE PRIVILEGES - Marriage & Family Therapist

Qualifications: Licensed by the Board of Behavioral Science Examiners; AND, Master's Degree in Psychology or Counseling; AND, One year multidisciplinary inpatient hospital experience as a therapist and/or experience as a master degree therapist. (Those not meeting the inpatient hospital experience are subject to a period of supervision by a qualified medical/AHP staff member, until they have satisfied the inpatient hospital experience requirement).

Individual psychotherapy/adult ___ ___ ___

ADVANCED PRIVILEGES - Marriage & Family Therapist

Qualifications: Applicants must meet the criteria outlined for the Core Marriage & Family Therapist privileges; AND, provide documentation of ability to perform the procedures requested via certification by a Training Director regarding experience and demonstrated competence.

Family/couple psychotherapy ___ ___ ___

Group psychotherapy ___ ___ ___

SPECIAL PRIVILEGES - Marriage & Family Therapist ___ ___ ___

Qualifications: Applicants must meet the criteria outlined for the Core and Advanced Marriage & Family Therapist privileges, and meet the criteria defined below for the specific privileges requested.

Hypnotherapy ___ ___ ___
Criteria: Requires forty (40) hours of approved hypnosis education, of which no less than ten (10) hours must be in a clinical setting. The applicant shall submit proof of hypnosis education hours by means of a certificate, transcript or similar document.

Biofeedback ___ ___ ___
Criteria: Requires documented training in core curriculum in Biofeedback; AND evidence of treating two cases in the past year. One successfullu supervised case will be required.

Evaluation for 5150 ___ ___ ___
Criteria: Applicants for this privilege must successfully completed all of the following:
1) Mental Status Exam

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2) Patients Rights in an Emergency Class
3) Legal Aspects Class
4) Written test including practice holds

ACKNOWLEDGEMENT OF THE ALLIED HEALTH PROFESSIONAL:

I have requested only those privileges for which I am qualified to perform, based upon my education, training, current experience and demonstrated performance. I understand that in exercising my practice privielges granted, I am constrained by hospital and medical staff policies and rules, including those outlined in the Allied Health Professional Rules and Regulations.

Signature of AHP: _____ Date: _____

Signature of Supervising Physician:_____ Date: _____

INTERDISCIPLINARY PRACTICE COMMITTEE RECOMMENDATION:

I have reviewed the requested practice privileges and supportive documentation for the above names applicant and recommend action on the privileges as noted above.

Applicant may perform practice privileges as indicated: _____ YES _____ NO

Exceptions/Limitations (Please Specify): _____

_____

APPROVALS

Interdisciplinary Practice Committee: _____ Date: _____

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Medical Executive Committee Date: _____

Board of Directors Date: _____