UNM SRMC
PSYCHOLOGIST SCOPE OF PRACTICE

Name:
Effective Dates: __________ To: __________

☐ Initial privileges (initial appointment)
☐ Renewal of privileges (reappointment)
☐ Expansion of privileges (modification)

INSTRUCTIONS
All new applicants must meet the following requirements as approved by the UNM SRMC Board of Directors effective: 03/21/2012

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications, and for resolving any doubts related to qualifications for requested privileges.

Clinical Service Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other requirements:
Note that privileges granted may be exercised only at UNM SRMC and in setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
QUALIFICATIONS FOR PSYCHOLOGIST

To be eligible to apply for clinical privileges as a Psychologist, the applicant must meet the following criteria:

Current clinical competence and an adequate volume of current experience documenting the ability to provide services at an acceptable level of quality and efficiency,

AND

Possess an earned doctorate degree (Ph.D. or Psy.D) in psychology from an accredited educational institution and have completed at least two (2) years of clinical experience in an organized health care setting supervised by a licensed psychologist, one year of which must have been post-doctoral, and an internship endorsed by the American Psychological Association,

AND

Current active certification and New Mexico license to practice.

AND

Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Governing Board.

Required Previous Experience: The successful applicant must be able to demonstrate that he or she has provided inpatient, outpatient, or consultative service to patients during the past 12 months.

PSYCHOLOGIST CLINICAL PRIVILEGES

Adolescent and adult patients except as specifically excluded from practice:

Diagnose, provide treatment and consultation to patients who suffer from mental, behavioral, or emotional disorders.

Privileges include but are not limited to:
Name: 
Effective Dates: __________ To: __________

- Family assessment/therapy
- Group therapy
- Marital or Couples therapy
- Neuropsychological testing
- Progress notes for individual therapy must be entered in the medical record within 24 hours. Psychological test results must be entered in the medical record within 48 hours of test administration
- Psychological assessment
- Psychotherapy

☐ Requested

### SPECIAL SERVICES/PROCEDURES

Successful completion of an approved, recognized course when such exists, or acceptable supervised training, and documentation of competence to obtain and maintain services as set forth in policies governing allied health professionals and the provision of specific services.

### PERIODIC COMPETENCE ASSESSMENT

Applicants must also be able to demonstrate they have maintained competence based on unbiased, objective results of care according to the hospital’s existing quality assurance mechanisms and by showing evidence that they have met the continued competence requirements established by the state licensing authority, applicable to the functions for which they are seeking to provide at this Hospital. In addition, continuing education related to the specialty area of practice is required as mandated by licensure.

### SPECIAL NON CORE PRIVILEGES (See Specific Criteria)

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.
QUALIFICATIONS FOR HYPNOTHERAPY

Criteria: Evidence of satisfactory completion of training in an accredited program such as a psychiatric residency training program at a University or one sponsored by an appropriate organization such as the American Psychiatric Association or the American Psychological Association; and evidence of satisfactory completion or training in the practice of hypnosis under the supervision of a person qualified for hypnosis; and evidence of continuing education and/or supervision in hypnosis by significant attendance at courses and/or publishing articles in journals or books of good standing during the past five years.

Required Previous Experience: Demonstrated current competence and evidence of the performance of hypnotherapy procedures in the past 12 months.

Maintenance of Privilege: Demonstrated current competence and the performance of procedures in the past 24 months.

☐ Requested

QUALIFICATIONS FOR BEHAVIORAL MODIFICATION/ThERAPy

Criteria: Completion of one (1) year of approved verifiable graduate training in a program which is approved by the American Psychiatric and/or American Psychological Association in which the modality was specifically taught and/or must be supervised by a fully licensed psychologist or psychiatrist independently privileged in this area.

Required Previous Experience: Demonstrated current competence and evidence of the performance of behavioral modification therapy procedures in the past 12 months.

Maintenance of Privilege: Demonstrated current competence and the performance of procedures in the past 24 months.

☐ Requested
BIOFEEDBACK THERAPY

Criteria: Certification by the Biofeedback Certification Institute of American or documented equivalent training and experience.

Required Previous Experience: Demonstrated current competence and evidence of the performance of biofeedback therapy procedures in the past 12 months.

Maintenance of Privilege: Demonstrated current competence and the performance of procedures in the past 24 months.

☐ Requested

NEUROPSYCHOLOGICAL TESTING

Criteria: Successful completion of systematic didactic and experiential training in neuropsychology and neuroscience at a regionally accredited university and two or more years of appropriate supervised training applying neuropsychological services in a clinical setting.

Required Previous Experience: Demonstrated current competence and evidence of the performance of neuropsychological testing procedures in the past 12 months.

Maintenance of Privilege: Demonstrated current competence and the performance of neuropsychological testing procedures in the past 24 months.

☐ Requested

Limited Ultrasound for Guided Procedure
☐ Check here to request Limited Ultrasound Guided Procedure privileges form (Separate form)
Acknowledgment of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM SRMC, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by 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 or related documents.

Signed _______________________________ Date _____________________

Clinical Service Chief's Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

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Notes:
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Print Name _______________________________ Signature _______________________________ Date _____________________

Clinical Service Chief or Designee Signature