

**UNIVERSITY OF MARYLAND MEDICAL CENTER**  
**Department of Psychiatry**  
**Delineation of Privilege Form**

Applicants for membership in the Department of Psychiatry of the University of Maryland Medical Center may request admission to the Active staff or the Courtesy staff.

**Please indicate the Staff Category to which you wish to apply:** (refer to Medical Staff Bylaws for qualifications)

\_\_\_\_\_ **Active**                      \_\_\_\_\_ **Courtesy**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinical Division:** \_\_\_\_\_

**Practice Sites:** \_\_\_ UMMC \_\_\_ VA \_\_\_ MPRC \_\_\_ WPCC \_\_\_ PA \_\_\_ USH \_\_\_ Other \_\_\_\_\_

**NOTE: Privileges marked with an asterisk (\*) also require approval of Moderate Sedation privilege (under Section 4)**

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes Write Not Approved if No
<b>Category 0:</b> In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of Medical Staff status, service or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. <i>*Approved per the Medical Staff Bylaws</i>	√*	Yes
<b>Category I –</b> To be eligible for Category I privileges, applicants must have completed an ACGME approved General Psychiatry residency and be Board Certified or a Candidate for Board Certification. <b>Category I privileges include: assessment and diagnosis, treatment planning and therapeutic techniques including behavioral and cognitive therapy, individual, group, couples &amp; family therapy, and psychopharmacology as well as psychosocial rehabilitation for patients of various ages and diagnoses.</b>		
<b>Category II –</b> To be eligible for Category II privileges, applicants must complete the requirements for Category I and must have completed a post-residency fellowship or board, added qualification and/or other certificate (attach certificate(s)). <b>While psychiatrists may see patients of various ages and diagnoses, the below recognizes areas of special competence and usually indicate a major commitment to patients or practice in this area.</b>		
<b>Subspecialties recognized by the ABPN and ABMS:</b>		
Child & Adolescent Psychiatry		
Geriatric Psychiatry		
Addiction Psychiatry		
Forensic Psychiatry		
<b>Subspecialties not recognized by the ABPN or ABMS, but with certification processes:</b>		
Administrative Psychiatry		
Psychoanalysis		
<b>Subspecialties not recognized by the ABPN or ABMS, and without certification processes but currently under consideration by the ABPN:</b>		
Consultation/Liaison Psychiatry		

Name: \_\_\_\_\_

DATE: \_\_\_\_\_

**NOTE: Privileges marked with an asterisk (\*) also require approval of Moderate Sedation privilege (under Section 4)**

Privilege/Operative Procedure	Check (√) if Requested	Chair Approval Initial if Yes, Write Not Approved if No
<b>Category III</b> – To be eligible for Category III privileges, applicants must have completed an ACGME approved General Psychiatry residency, be Board Certified or a Candidate for Board Certification, and have additional training and/or experience. Complete attached documentation sheet for each specialized procedure/practice requested.		
<b>Specialized Procedures:</b>		
Biofeedback		
Electroconvulsive Therapy		
Hypnosis		
Sexual Therapy		
Sodium Amytal Interview *		
Other: _____ _____		
<b>Specialized Practice:</b>		
Child & Adolescent Psychiatry		
Geriatric Psychiatry		
Addiction Psychiatry		
<b>Category IV: Special/Cross Disciplinary Procedures:</b>		
<b>Moderate (Conscious) Sedation</b> - Criteria for Approval: 1. Proof of Current BCLS certification (please attach); 2. Completion of age-appropriate basic airway management in-service by the UMMC Department of Anesthesia (and every two years thereafter for reappointment). <i>(Physicians board certified in Anesthesiology, Critical Care Medicine, Emergency Medicine, Neonatology, or Oral &amp; Maxillofacial Surgery are not required to fulfill criteria 2.)</i>		

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Supervisor

\_\_\_\_\_  
Date

I attest that in making this appointment, due consideration has been given to the applicant's professional performance, judgement and technical skill prior to the appointment period. I have not observed or been informed of conduct indicating a present or potential health problem that affects the applicant's ability to perform clinically or to fulfill staff obligations.

\_\_\_\_\_  
Anthony Lehman, MD  
Chairman, Department of Psychiatry

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Confirming Signature  
*(required if any requested privilege is not approved)*

\_\_\_\_\_  
Date

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
DEPARTMENT OF PSYCHIATRY**

**Documentation of Application for Specialized  
Procedures/Practices in Psychiatry**

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Nature of Specialized Procedure/Practice: (Complete one for each procedure/practice requested. Use additional paper if needed.)

1. Describe all didactic/clinical training received in this specialty area:
  
  
  
  
  
  
  
  
  
  
2. List supervised experiences you have had:
  
  
  
  
  
  
  
  
  
  
3. Have you ever been named in any malpractice action or had your clinical privileges limited, suspended or revoked while working in this specialty area, or utilizing this specialized procedure. (If YES, please explain)
  
  
  
  
  
  
  
  
  
  
4. Provide name, address and telephone number of a professional who can attest to your expertise in this specialty. Upon completion of this form, have this individual sign in support of your application. Note that this individual should be a recognized authority themselves in this specialty or a previous supervisor with significant knowledge of your expertise.

\_\_\_\_\_  
**Name (Please PRINT or TYPE)**

\_\_\_\_\_  
**Address**

\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**I attest to the accuracy of the information provided above:**

\_\_\_\_\_  
**Signature of Applying Psychiatrist**

\_\_\_\_\_  
**Date**

**UNIVERSITY OF MARYLAND MEDICAL CENTER  
DEPARTMENT OF PSYCHIATRY**

**Documentation of Application for Specialized  
Procedures/Practices in Psychiatry**

**NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

1. Describe your practice activity (site, volume of service, age and diagnostic diversity, therapeutic techniques used, etc.) For each practice are requested:
  - A. General
  - B. Subspecialty
  - C. Specialized Procedures (biofeedback, hypnosis, ETC, etc.)
  - D. Specialized Practice (child, geriatric, addiction, etc.)
2. List all continuing education activities since the last application for privileging that support the current requested clinical privileges (include dates, topic and credits obtained).
3. Have you obtained any additional licenses or certifications (list date obtained and details).

**I attest to the accuracy of the information provided above:**

\_\_\_\_\_  
**Signature of Applying Provider**

\_\_\_\_\_  
**Date**

- 
4. Utilization Review, Risk & Quality Management and Peer Review Information was evaluated in the re-credentialing process.

\_\_\_\_\_ YES

\_\_\_\_\_ NO