

**Shock Trauma Center
Delineation of Clinical Privileges
Section of Rehabilitation**

Type of Request: ____ Initial ____ Renewal

Name: _____ Date: _____

Please check areas in which privileges are requested.

Procedures	Check if Privilege Requested	Chair Approval Initial if Yes Write No if Not Approved
Perform patient histories		
Perform physical examinations		
Perform neurological exams		
Perform neurological assessments		
Participate in consultation services for Physical Medicine and Rehabilitation Medicine		
Other (please Specify):		

Applicant's Signature Date

Chief, Section of Rehabilitation Date
Shock Trauma Center

Clinical Director Date
Shock Trauma Center

Applicant Verification Signature Date
(to be completed if privilege(s) is/are not approved)