Contra Costa Regional Medical Center
Privileges Request Form

Practitioner Name: _____

Departments (s)	Number	Privilege Descriptions D= With Direct Supervision C= With Consultation U= Unrestricted	D/C/U	Training/ Education	Experience	Current Competence	Requested	Granted	D= Denied P= Pending CNM=Criteria Not Met
		Psychology							
PSO	PSO 1	Psychological Testing- Adults	D	Psy.D/Ph.D	N/A	N/A			
			C	Psy.D/Ph.D	6 mos	4 cases in last 4 years			
			U	Psy.D/Ph.D	2 years	20 cases in last 4 years			
PSO REH	PSO 2	Neuropsychological Testing- Adults	D	Psy.D/Ph.D	N/A	N/A			
			C	Psy.D/Ph.D	6 mos	10 cases in last 4 years			
			U	Psy.D/Ph.D and Post-Doc Training	2 years	20 cases in last 4 years			
PSO	PSO 3	Outpatient Screening and Crisis Counseling	C	Psy.D/Ph.D	6 mos	N/A			
			U	Psy.D/Ph.D	1 year	1 year in last 4 years			
PSO	PSO 4	Psychotherapy	C	Psy.D/Ph.D	N/A	N/A			
			U	Psy.D/Ph.D	N/A	1 year last 4 years			

I certify that I have reviewed the Contra Costa Regional Medical Center Privilege Criteria, and that I meet the specified criteria for education/training, experience, and current competence for the privileges that I have indicated above.

_____ _____
Signature of Requesting Practitioner Date

_____ _____
Signature of Divison Chairperson Date

_____ _____
Signature of Department Chairperson Date

*** Separate proctoring required**