University of Michigan
Hospitals and Health Centers

Delineation of Privileges
Department of Internal Medicine/Division of Gastroenterology
Psychologist

Name: _____
Please Print or Type

LEVEL I CORE PRIVILEGES

PSYCHOLOGIST

Minimum Training and Experience
Requires a doctoral degree (e.g., Ph.D., Psy. D.) from an accredited university program in Psychology, at least one year of training in an accredited internship in clinical psychology, and full licensing as a Psychologist in the State of Michigan.

Scope of Practice/Privileges
The scope of practice includes the psychological consultation, diagnosis and treatment of all adult syndromes listed in the American Psychiatric Association Diagnostic and Statistical Manual V (or latest edition). This may include developmental/familial disorders, dementia, and other disorders presenting with neurocognitive symptoms, mental disorders due to a general medical condition, substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, factitious disorders, dissociative disorders, sexual and gender identity disorders, eating disorders, sleep disorders, impulse control disorders, adjustment disorders, or other disorders associated with psychological or behavioral disturbance. The Psychologist may provide psychological consultation and interventions for patients with other medical disorders that are caused by, present with, or are exacerbated by psychological factors (e.g., gastrointestinal disorders, chronic medical illness, traumatic brain injury, stroke, chronic pain, fatigue, somatic preoccupation, hypertension, cardiovascular disease, cancer, and stress-related psychophysiologic disorders). Treatments and diagnostic procedures include: cognitive behavioral therapy, behavioral therapy, relaxation skills training, medical hypnosis, psychotherapy, group therapy, family therapy, psychological assessment, and consultation/liaison.

☐ **Requested (Applicant)** ☐ **Recommended approval (Service Chief/Chair)**

TO BE COMPLETED BY APPLICANT:

I meet the previously stated minimum criteria and request that my application be considered for the privileges as outlined above. I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the Medical Staff of The University of Michigan Health System.

Applicant Signature: _____ Date: _____

DEPARTMENT ACTION:
Approval:

☐ As Requested ☐ As Modified (please explain) _____

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Justification for approval is based on careful review of the applicant's education, postgraduate clinical training, demonstrated clinical proficiency and Board Certification or qualifications to sit for the Boards.

Department Chair: _____ Date: _____ Service Chief: _____ Date: _____

CREDENTIALS COMMITTEE ACTION:

☐ Approval as Requested ☐ Not Approved (please explain) _____

Credentials Committee Member: _____ Date: _____

EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS ACTION:

☐ Approval as Requested ☐ Not Approved (please explain) _____

Executive Committee On Clinical Affairs - Member: _____ Date: _____