LIST OF CLINICAL PRIVILEGES – SPEECH LANGUAGE PATHOLOGY

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.
ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from military service.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Clinical Supervisor
CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form and forward the form to the Credentials Office.
CODES: 1. Fully competent within defined scope of practice.
2. Supervision required. *(Unlicensed/uncertified or lacks current relevant clinical experience).*
3. Not approved due to lack of facility support. *(Reference local facility privilege list. Use of this code is reserved for the Credentials Committee/Function.*)
4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.
CHANGES: Any change to a verified/approved privileges list must be made in accordance with Service specific credentialing and privileging policy.

NAME OF APPLICANT:

NAME OF MEDICAL FACILITY:

ADDRESS:

I Scope		**Requested**	**Verified**
P389160	The scope of practice for Speech Pathologists includes the evaluation, diagnosis, treatment, and consultation for patients of all ages with speech, language, cognitive-communication, swallowing, fluency, and/or voice disorders. Speech pathologists refer to and recommend appropriate referrals to physicians, audiologists, other healthcare providers and to educators.		
Diagnosis and Management (D&M)		**Requested**	**Verified**
P389162	Evaluation and management of total laryngectomy patients including selection of patients for tracheo-esophageal voice prosthesis		
P389164	Evaluation and treatment of patients with tracheostomy one-way speaking valve		
P389166	Evaluation and treatment of patients with tracheostomy in-line speaking valve (ventilator patients)		
P389168	Provide augmentative and alternative communication (AAC) evaluation and treatment to include speech generating and non-speech generating devices		
P389170	Oromyofunctional assessment and treatment		
P389172	Evaluation and treatment for irritable larynx syndrome including paradoxical vocal fold dysfunction and chronic cough		
P389174	Newborn and pediatric evaluations of swallowing disorders		
P389176	Fitness for duty examinations		
Procedures		**Requested**	**Verified**
P389178	Sizing, fitting and inserting tracheo-esophageal voice prosthesis		
P389180	Modified Barium Swallow (MBS) study in consultation with Radiology, with adults and/or newborn/pediatric patients		
P389182	Fiberoptic endoscopic evaluation of swallow (FEES)		
P389184	Flexible videoendoscopy and laryngeal stroboscopy to evaluate and treat voice disorders		
P389186	Rigid (oral) endoscopy to evaluate and treat voice disorders		
P389188	Laryngeal function studies including acoustic voice analysis using Computerized Speech Lab (CSL)		
P389190	Nasometric assessment of velopharyngeal function		
Other (Facility- or provider-specific privileges only):		**Requested**	**Verified**

SIGNATURE OF APPLICANT	**DATE**

II	CLINICAL SUPERVISOR'S RECOMMENDATION

☐ RECOMMEND APPROVAL ☐ RECOMMEND APPROVAL WITH MODIFICATION (Specify below) ☐ RECOMMEND DISAPPROVAL (Specify below)

STATEMENT:

CLINICAL SUPERVISOR SIGNATURE	CLINICAL SUPERVISOR PRINTED NAME OR STAMP	DATE