

**LIST OF CLINICAL PRIVILEGES –PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER**

**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 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
P385076	The scope of privileges for psychiatric mental health nurse practitioners includes provision of comprehensive psychiatric and mental healthcare, to include the conduct of biopsychosocial assessment, treatment, education, health promotion and disease prevention to patients, families and the community. They provide crisis oriented care and therapeutic counseling/psychotherapy to individuals, couples, families and groups.		
<b>Diagnosis and Management (D&amp;M)</b>		<b>Requested</b>	<b>Verified</b>
P385998	Prescribe medications in accordance with Military Treatment Facility (MTF) Pharmacy and Therapeutics (P&T) policy		
<b>D&amp;M Advanced Privileges (Requires Additional Training):</b>		<b>Requested</b>	<b>Verified</b>
P385080	Diagnose, treat and manage mental disorders of child-adolescent populations.		
	<b>Therapies</b>	<b>Requested</b>	<b>Verified</b>
P388943	Individual therapy		
P388945	Group therapy		
P388947	Family therapy		
P388949	Marital/couple therapy		
<b>Procedures</b>		<b>Requested</b>	<b>Verified</b>
	N/A		
<b>Other (Facility- or provider-specific privileges only):</b>		<b>Requested</b>	<b>Verified</b>
<b>SIGNATURE OF APPLICANT</b>		<b>DATE</b>	

**LIST OF CLINICAL PRIVILEGES – PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER (CONTINUED)**

**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**