GEORGIA DEPARTMENT OF CORRECTIONS - MENTAL HEALTH SERVICES
REQUEST FOR CLINICAL PRIVILEGES

Applicant's Name:_____ Title:_____
Date:_____
Your request for clinical privileges in the areas you requested have been carefully considered. Based upon your qualifications and experience the privileges listed below have been either approved or disapproved.

	Requested	Approved		Disapproved
1. Counseling		With Supervision	Without Supervision	
A. Supportive Counseling (individual)				
B. Psycho educational training (group)				
C. Case Management				
D. Life Skills Training				
II. Therapy				
A. Individual Therapy				
B. Group Therapy				
C. Sexual Abuse Therapy				
D. Crisis Intervention				
III. Evaluations				
A. Mental Health Reception Screen				
B. Mental Health Service Screen				
C. On-Call Crisis Triage				
D. Sexual Abuse Evaluation				
E. Disciplinary Evaluation				
F. Administrative Segregation Evaluation				
G. Parole Psychological Evaluation				
IV. Psychological Testing (Administration & Scoring)				
A. Intelligence				
B. Objective Personality				
C. Projective Personality				
D. Neuropsychological				

_____ _____
Applicant's Signature Date

_____ _____
Clinical Supervisor's/Consultant's Signature/Title Date

Retention Schedule: Upon completion, the original of this form shall be placed in the applicant's/staff member's credentialing/privileging file and a copy will go to the applicant/staff member. The form will be completed annually.