**APPLICATION FOR CLINICAL PRIVILEGES**

**CHIROPRACTIC**

Applicant: Please check the procedures for which you are requesting or not requesting. Do not leave any blanks. Once this is completed please return to the practice manager along with any other information that has been requested from you. The Medical Director/Credentialing Committee will then grant or deny privileges. You will be notified of the results, via a copy this form.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Procedure | Decision | | | | Comments |
| **Chiropractic:** |  |  |  |  |  |
| Manipulates |  requested |  not requested |  granted |  denied |  |
| Spine-Cervical, Thoracic, Lumbar |  requested |  not requested |  granted |  denied |  |
| Pelvis, Both Shoulders, Both  Hips, Pelvic Ring, and SI Joints |  requested |  not requested |  granted |  denied |  |
| Other |  requested |  not requested |  granted |  denied |  |
| Other |  requested |  not requested |  granted |  denied |  |
| Other |  requested |  not requested |  granted |  denied |  |
| Other |  requested |  not requested |  granted |  denied |  |
| Other  Other |  requested |  not requested |  granted |  denied |  |
| Other |  requested |  not requested |  granted |  denied |  |

**Clinical Privileges Delineation Form**

**CHIROPRACTIC**

I am mentally and physically capable of performing the privileges, which I have requested:

Signature Date \_ Name, please print \_

*Office use only*

These privileges will be granted by the governing board and the credentialing committee. The

privileges are renewed every (2) years. The applicant may request to have privileges changed as required during this period.

Signed Medical Director/Members of the Credentialing Committee Date