CompHealth

CLINICAL CAPABILITIES

Psychiatry

Please list any limitations or comments you may have on a separate sheet

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname
			Date of Birth	

CERTIFICATIONS ☐ BLS expires: _____ ☐ ACLS expires: _____ ☐ PALS expires: _____

POPULATIONS WORKED WITH ☐ Adults ☐ Pediatrics* (**Verification of specialty training in child/adolescent psychiatry may be required.)*

AREAS OF INTEREST ☐ Crisis intervention/ER psychiatry ☐ Correctional facilities ☐ Addiction

SCOPE OF PRACTICE

Please be aware that this form constitutes your application to be credentialed for specific areas and procedures while on assignments through CompHealth.

The Credentialing Committee may not consider for approval clinical capabilities where a box is not checked.

Please check the box indicating which clinical capabilities you are able to perform, and where indicated, list the approximate number performed within the last 24 months.

Outpatient settings - ☐ Office/clinic

☐ Day treatment center

Inpatient settings – ☐ Acute psychiatric unit/institute (typically closed unit or restrictive setting)

☐ Familiarity with involuntary commitments

☐ Familiarity with seclusions

☐ Familiarity with restraint protocols

☐ Sub-acute psychiatric unit/residential treatment facility (typically voluntary)

☐ Long-term psychiatric facility (e.g., state hospital, VA)

Clinical Areas

☐ Anxiety disorders (PTSD, generalized anxiety, phobias, OCD, etc.)

☐ Affective disorders (Bipolar illness, major depression, etc.)

☐ ADD/ADHD

☐ Personality disorders (Borderline, anti-social, etc.)

☐ Eating disorders

☐ Developmental disorders

☐ Psychotic disorders (Schizophrenia, medically induced, etc.)

☐ Organic disorders (Dementia, traumatic brain injury, etc.)

Treatment Techniques

☐ Pharmacotherapy

Rx of: ☐ Anti-depressants

☐ Anxiolytics

☐ Mood stabilizers

☐ Anti-psychotics

☐ Substance abuse agents

☐ Group therapy

☐ Family therapy

☐ ECT #

If you work with pediatrics populations and are not child/adolescent trained, describe the age range and clinical areas worked with: _____

I affirm that all information given on this page is true and accurate. **Initials** _____ **Date** _____

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