



SCOPE OF SERVICES
Psychiatry

Last Name	First Name	Middle Name
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Check appropriate box indicating which clinical capabilities you are able to perform
Please list any limitations on a separate sheet

Specialized Procedures			
<input type="checkbox"/>	Electroconvulsive Therapy	<input type="checkbox"/>	Adolescent Treatment
<input type="checkbox"/>	Sodium Amytal	<input type="checkbox"/>	Radiologic Procedures
<input type="checkbox"/>	Hypnotherapy	<input type="checkbox"/>	(Requires separate application)
<input type="checkbox"/>	Behavior Modification	<input type="checkbox"/>	Child Psychiatry
<input type="checkbox"/>	BioFeedback	<input type="checkbox"/>	Psychoanalysis
<input type="checkbox"/>	Sexual Therapy	<input type="checkbox"/>	Forensic Psychiatry
<input type="checkbox"/>	Alcohol and Drug Treatment	<input type="checkbox"/>	geropsychiatry
<input type="checkbox"/>	Family and Group Therapy	<input type="checkbox"/>	Other, Specify:
<input type="checkbox"/>	Individual Psychotherapy	<input type="checkbox"/>	Other, Specify:
<input type="checkbox"/>	Psychopharmacology	<input type="checkbox"/>	

Signing below indicates that I am qualified to perform the services chosen on the checklist

Signature

Date