900 N MICHIGAN SURGICAL CENTER

PRIVILEGE REQUEST FORM
NUTRITIONIST/DIETARY

I am applying for the following privileges of which I am also currently credentialed at ________________________________, an Illinois hospital.

REQUESTED	GRANTED	PROCEDURE
____________	___________	Evaluate and Treat obesity related diseases, such as Hypertension, Hyperlipidemia, Diabetes, and Sleep Apnea prior to and after weight loss surgery or in general
____________	___________	Evaluate and Treat Nutritional deficiencies prior to and after weight loss surgery
____________	___________	Assist Patients with medically supervised weight loss (diet and exercise counseling, medications etc.)
____________	___________	Assist with Insurance requirements prior to weight loss surgery
____________	___________	Lap Band Adjustments
____________	___________	**Regional (Please Specify):** ______________________ ______________________ ______________________
____________	___________	**General (Please Specify):** ______________________ ______________________ ______________________
____________	___________	**Other (Please Specify):** ______________________ ______________________ ______________________

Practitioner's Signature Print Name Date

Medical Director Approval Date

Governing Body Approval Date

REVISED: 09/08