

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 _____