

## Specialty Attestation

**UBH/USBHPC/LEI requires additional training and/or experience for the following populations, professionals, and specialties. Please review Specialty Requirements as attached.**

I have reviewed the UBH/USBHPC/LEI Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet UBH/USBHPC/LEI requirements for that treatment area.

- Preschool (0-5 years)
- Children (6-12 years)
- Adolescents (13-18 years)
- Geriatrics
- Chemical Dependency/Substance Abuse
- Certified Employee Assistance Professional (submit CEAP certificate)
- Critical Incident Stress Debriefing (submit CISD certificate)
- Disability Evaluation/Management
- Employee Assistance Professional (submit UBH EAP questionnaire)
- Eating Disorders
- Neuropsychological Testing
- Pervasive Development Disorder
- Substance Abuse Professional (submit Department of Transportation certificate)
- Worker's Compensation
- Nurses–Prescriptive Privileges (submit ANCC certificate based upon state requirements)

I understand that UBH/LEI may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with a UBH documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the UBH/USBHPC/LEI network.

Further, by checking the box below, I understand that I have not indicated any specialties as applicable to my training.

No Specialties

**Please note that standard credentialing criteria must be met before specialty designation can be considered. All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.**

Printed Name of Applicant: \_\_\_\_\_

Signature of Applicant\*\*: \_\_\_\_\_ Date: \_\_\_\_\_

(\*\*) Signature stamps are not accepted.

**PHYSICIAN SPECIALTY REQUIREMENTS**

**Important Note:** Signature of the Specialty Attestation is required

<p><b><u>PRESCHOOL/CHILDREN:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an ACGME approved Child Fellowship <b>OR</b> recognized certification in Child Psychiatry</li> </ul> <p><b>AND (1) one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CME in preschool/children in the last twenty-four (24) month period</li> <li>▪ Evidence of at least twenty-five percent (25%) of practice experience in the treatment of preschool/children</li> </ul>
<p><b><u>ADOLESCENTS:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an ACGME approved Child and Adolescent Fellowship <b>OR</b> recognized certification in Adolescent Psychiatry</li> </ul> <p><b>AND (1) one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CME in adolescents in the last twenty-four (24) month period</li> <li>▪ Evidence of at least twenty-five percent (25%) of practice experience in treating adolescent patients</li> </ul>
<p><b><u>GERIATRICS:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an ACGME approved Geriatric Fellowship <b>OR</b> recognized certification in Geriatric Psychiatry</li> </ul> <p><b>AND (1) one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CME in Geriatrics in the last twenty-four (24) month period</li> <li>▪ Evidence of at least twenty-five percent (25%) of practice experience in treating geriatric patients</li> </ul>
<p><b><u>CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an ACGME approved fellowship in Addiction Medicine <b>OR</b> Certification in Addiction Medicine or ASAM</li> </ul> <p><b>AND (1) one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CME in Substance Abuse in the last twenty-four (24) month period</li> <li>▪ Evidence of at least twenty-five percent (25%) of practice experience in substance abuse</li> </ul>
<p><b><u>CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an ACGME approved fellowship in Addiction Medicine <b>OR</b> Certification in Addiction Medicine or ASAM</li> </ul> <p><b>AND (1) one or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CME in Substance Abuse in the last twenty-four (24) month period</li> <li>▪ Evidence of at least twenty-five percent (25%) of practice experience in substance abuse</li> </ul>
<p><b><u>DISABILITY:</u></b></p> <ul style="list-style-type: none"> <li>▪ Experience or training in performing functional capacity evaluations for disability or worker's compensation, or as a qualified independent medical examiner.</li> <li>▪ Thorough review of the Disability Solutions<sup>SM</sup> Psychiatric Disability Management Program Clinician Manual and signed Memorandum of Understanding in agreement with our Disability Solutions protocols</li> </ul>
<p><b><u>EATING DISORDERS:</u></b></p> <ul style="list-style-type: none"> <li>▪ One (1) year fellowship, internship or practice in Eating Disorders, completed at an accredited institution or approved program</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>▪ Evidence of at least one (1) year professional experience with at least twenty-five percent (25%) of practice in the treatment of eating disorders</li> <li>▪ Ten (10) hours of CME in Eating Disorders in the last twenty-four (24) month period</li> </ul>
<p><b><u>PERVASIVE DEVELOPMENTAL DISORDER:</u></b></p> <ul style="list-style-type: none"> <li>▪ Six (6) months full-time clinical work in a PDD clinic or structured PDD setting within past five (5) years<b>OR</b></li> <li>▪ Twenty percent (20%) of current practice involved in the assessment and treatment of patients with PDD</li> </ul>
<p><b><u>WORKER'S COMPENSATION:</u></b></p> <ul style="list-style-type: none"> <li>▪ Twenty-four (24) months experience assessing and treating worker's compensation cases</li> </ul>

## PSYCHOLOGISTS & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS

**Important Note:** Signature of Specialty Attestation is Required

<p><b><u>PRESCHOOL/CHILDREN:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an APA approved or other accepted training program in Child Psychology</li> </ul> <p><b>AND one (1) or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CEU in preschool/children in the last 24 month period</li> <li>▪ Evidence of at least twenty-five (25%) of practice experience in the treatment of preschool/children</li> </ul>	<p><b><u>DISABILITY:</u></b></p> <ul style="list-style-type: none"> <li>▪ Experience or training in performing functional capacity evaluations for disability or worker's compensation</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Experience or training in at least 2 of these 4 categories: EAP counseling, managing stress in the workplace, co-morbid medical conditions or substance abuse</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>▪ Thorough review of the Disability Solutions<sup>SM</sup> Psychiatric Disability Management Program Clinician Manual and signed Memorandum of Understanding in agreement with our Disability Solutions protocols</li> </ul>
<p><b><u>ADOLESCENTS:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an APA approved or other accepted training program in Adolescent Psychology</li> </ul> <p><b>AND one (1) or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CEU in adolescents in the last 24 month period</li> <li>▪ Evidence of at least 25% of practice experience in treating adolescent patients</li> </ul>	<p><b><u>EMPLOYEE ASSISTANCE PROFESSIONAL (EAP):</u></b></p> <ul style="list-style-type: none"> <li>▪ Must pass UBH/USBHPC/LEI EAP questionnaire, <b>and</b></li> <li>▪ Minimum of two (2) years experience in the delivery of EAP core technology as defined by EAPA, <b>and</b></li> <li>▪ Minimum of one (1) annual training (CEU credits or professional development hours) in any of the six (6) EAP content areas</li> </ul>
<p><b><u>GERIATRICS:</u></b></p> <ul style="list-style-type: none"> <li>▪ Completion of an APA approved or other accepted training program in Geriatric Psychology</li> </ul> <p><b>AND one (1) or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CEU in Geriatrics/Gerontology in the last twenty-four (24) month period</li> <li>▪ Evidence of twenty-five (25%) of practice experience in treating geriatric patients</li> </ul>	<p><b><u>EATING DISORDERS:</u></b></p> <ul style="list-style-type: none"> <li>▪ One (1) year fellowship, internship or practice in Eating Disorders, completed at an accredited institution or approved program</li> </ul> <p><b>AND</b></p> <ul style="list-style-type: none"> <li>▪ Evidence of at least one (1) year professional experience with at least twenty-five (25%) of practice in the treatment of eating disorders</li> <li>▪ Ten (10) hours of CEU in Eating Disorders in the last twenty-four (24) month period</li> </ul>
<p><b><u>CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:</u></b></p> <ul style="list-style-type: none"> <li>▪ Complete an APA or other accepted training in Addictionology</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Certification in Addiction Counseling</li> </ul> <p><b>AND one (1) or more of the following:</b></p> <ul style="list-style-type: none"> <li>▪ Ten (10) hours of CEU in Substance Abuse in the last twenty-four (24) month period</li> <li>▪ Evidence of twenty-five (25%) practice experience in substance abuse</li> </ul>	<p><b><u>PERVASIVE DEVELOPMENTAL DISORDER:</u></b></p> <ul style="list-style-type: none"> <li>▪ Six (6) months full-time clinical work in a PDD clinic or structured PDD setting within past 5 years</li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>▪ Twenty percent (20%) of current practice involved in the assessment and treatment of patients with PDD</li> </ul>
<p><b><u>CERTIFIED EMPLOYEE ASSISTANCE PROFESSIONAL (CEAP):</u></b></p> <ul style="list-style-type: none"> <li>▪ Certificate from the Employee Assistance Certification Commission</li> </ul>	<p><b><u>SUBSTANCE ABUSE PROFESSIONAL:</u></b></p> <ul style="list-style-type: none"> <li>▪ Certificate of training in federal Department of Transportation SAP functions and regulatory requirements (agencies providing such certification include, but not limited to, Blair and Burke, EAPA and NMDAC)</li> </ul>
<p><b><u>CRITICAL INCIDENT STRESS DEBRIEFING:</u></b></p> <ul style="list-style-type: none"> <li>▪ Certificate of CISD training from American Red Cross or Mitchell model</li> <li>▪ Documentation of training and CEU units in the provision of CISD services</li> </ul>	<p><b><u>WORKER'S COMPENSATION:</u></b></p> <ul style="list-style-type: none"> <li>▪ Twenty-four (24) months experience assessing and treating worker's compensation cases</li> </ul>

**THE INFORMATION CONTAINED HEREIN IS PROPRIETARY & CONFIDENTIAL**

**NEUROPSYCHOLOGICAL TESTING – Psychologist Only**

- Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology
- OR**
- Completion of courses in Neuropsychology including: Neuroanatomy, Neuropsychological testing, Neuropathology, or Neuropharmacology
  - Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution
- AND**
- Two (2) years of supervised professional experience in Neuropsychological Assessment

**NURSES REQUESTING PRESCRIPTIVE AUTHORITY MUST:**

- Possess a currently valid license as a Registered Nurse in the state(s) in which you practice
- Be authorized for prescriptive authority in the state in which you practice
- Meet state specific mandates for the state in which you practice regarding DEA license and physician supervision
- Attest that you meet your state's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the UBH/USBHPC/LEI application above