

**HEALTH CENTER**  
**REGISTERED DIETITIAN DELINEATION OF PRIVILEGES**  
 (Family Practice)

Applicant's Name	Title			Date
<b>Practice/Procedure</b>	<b>Current</b>	<b>Requested</b>	<b>Provisional</b>	<b>Recommended</b>
1. Complete nutrition assessments of patients				
2. Provide instructions/education on appropriate diet (in the absence of a specific diet ordered by a physician) as follows:				
2(a) Provide diet education to adults				
2(b) Provide pediatric diet education to supporting families or caretakers				
2(c) Provide diabetic group education				
2(d) Provide general diabetes education, <b>not including medication education</b>				
3. Perform anthropometric measurements of patients (including height, weight, and bioimpedence analysis)				

- Applicant attests that clinical training provided adequate instruction and experience for requested privileges.
- Applicant understands that the completion of this form does not preclude applicant from requesting additional privileges at a later date.
- Applicant understands that clinical privileges expire and must be renewed after two years.

Signatures of applicant, Department Director, and Chief Medical Officer affirm the ability of applicant to perform the mental and physical tasks necessary for the scope of practice requested.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Department Director \_\_\_\_\_ Date \_\_\_\_\_

Signature of Chief Medical Officer \_\_\_\_\_ Date \_\_\_\_\_

Signature of Secretary, Board of Directors \_\_\_\_\_ Date \_\_\_\_\_