

DELINEATION OF PRIVILEGES RECORD

For use of this form, see AR 40-68; the proponent agency is DTSG

1 PERIOD
FROM

TO

2. Initial the Appropriate Category

A. Anesthesia	I. Pediatrics	Q. Nurse Practitioners (Adult)
B. Dentistry	J. Podiatry	R. Nurse Practitioners (Pediatric)
C. Family Practice	K. Psychiatry	S. OB/GYN Nurse Practitioners
D. Internal Medicine & Subspecialty	L. Psychology	T. Physician Assistants
E. Neurology	M. Radiology/Nuclear Medicine	U. Emergency Medicine
F. Obstetrics & Gynecology	N. Surgery	V. Other Specialty (Specify)
G. Optometry Service	O. Nurse Anesthetists	
H. Pathology	P. Nurse Midwives	

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC Brooke Army Medical Center Fort Sam Houston, Texas 78234-6200		B. APPOINTMENT TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Active <input type="checkbox"/> Affiliate <input type="checkbox"/> Temporary <input type="checkbox"/> None	C. PRIVILEGE CATEGORY <input type="checkbox"/> Regular <input type="checkbox"/> Temporary <input type="checkbox"/> Supervised
D. DEPT/SVC (Specify)	E. DATE	G. CREDENTIALS COMMITTEE JENICE N. LONGFIELD, COL, MC Chairperson	H. DATE
F. SIGNATURE		I. SIGNATURE	

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER DANIEL F. PERUGINI, BG, MC COMMANDING	B. SIGNATURE	C. DATE
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5. Remarks ADMITTING PRIVILEGES: YES NO CLINICAL PRIVILEGES: Granted as Requested Modified as Recommended

A review has been made of the provider's verified licensure, education and training, experience, capability to perform the requested privileges and demonstrated current competence.

There are no changes to the previous delineation of privileges _____ Date _____

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM (Date)	B. BOARD EXAMINATION TAKEN (Date) <input type="checkbox"/> Total <input type="checkbox"/> Partial	C. BOARD CERTIFIED <input type="checkbox"/> No <input type="checkbox"/> Yes (Give Name of Board)
D. RECERTIFICATION (Board and Date)	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING (Specify only training since initial application)
G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD (Specify)	J. NAME OF APPLICANT OR PRACTITIONER
I. MEMBERSHIP IN SPECIALTY SOCIETIES (Specify)	K. SIGNATURE	L. DATE

MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-68, the proponent agency is OTSG.

Authority:	Title 5, United States Code (USC), Section 3109 and 3301 (Title 5, USC. Section 52a)
Principle Purpose:	To obtain US Civil Service Appointment.
Routine uses:	Basis for determination of qualifications and backround information for the eligibility for appointment. Basis for credentialing providers.
Disclosure:	Disclosure of information required is voluntary. However, failure to provide the required information will result in nonacceptability of the application.

The policy of the Army is to screen, verify and validate statements, assertions and documents of all applicants for health care positions. As part of the process, please complete the following statements (as applicable to your profession).

1. NAME:	2. Social Security Number
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YES (Have)	NO (Have Not)	Brooke Army Medical Center, 3851 Roger Brooke Drive, Bldg 3600 Fort Sam Houston, TX 78234-6300
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		3. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice within the last 7 years or since you last appointment? (List any affirmative answers on the reverse of form.)
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		4. I AM LICENSED/REGISTERED/CERTIFIED by the authority listed in Item 11c.(List all current and inactive licenses by state, numbers, and dates.) List any license that may have been suspended, revoked, or previously held on the reverse side of this form of this form if applicable. VOLUNTARY/INVOLUNTARY
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		5. Had my professional license denied, withdrawn, or restricted by a state or local licensing board or other authority. (If affirmative, give the organization, address, and date of involvement in Item 13 below.) VOLUNTARY or INVOLUNTARY
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		6. Had professional privileges denied, withdrawn, or restricted by a health care facility. (If affirmative, give the organization, address, and dates involved on reverse.) VOLUNTARY or INVOLUNTARY.
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		7. Resigned or otherwise disassociated myself from employment/practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. (If yes, give the organization name, address, and dates involved on reverse.) VOLUNTARY or INVOLUNTARY.
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		8. Are you now or have you ever been required to appear before any medical or state regulating authority regardless of the results, concerning, your status as an impaired, hindered, or otherwise restricted practitioner? (If affirmative, give brief description on reverse.)
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		9. Had a history of drug or alcohol abuse or misuse. (If yes, explain in Item 13 below or on reverse.) Please provide dates, type of treatment, and if enrolled in recovery programs.)
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		10. Do you have any disease or impairment which would make your appointment a hazard to yourself or others to perform within the level of privileges requested? (If yes, give brief description on reverse.)
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		11. I hereby authorize the U.S. Army to contact my MALPRACTICE CARRIER/LICENSING organization for the purpose of verifying the above information.
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		11a. CARRIER (Name and Address) _____ _____ _____	11b. POLICY NO.	
			11c. Licensing Organization	
			State _____	
			Number _____	
			Expiration _____	

		12. I hereby authorize the U.S. Army to contact the following institution(s) for the purpose of verifying the status of my current professional privileges.
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		12a. ORGANIZATION NAME/ADDRESS _____ _____ _____	12B. DATE(S) _____ _____
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13. Clarification/Explanation.etc: (continue on reverse if necessary)

14a. Type/Print Name of Applicant	14b. SIGNATURE OF APPLICANT	14c. Date

STATEMENT OF AFFIRMATION/RELEASE OF INFORMATION

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS IN OR OMISSIONS FROM THIS APPLICATION CONSTITUTE CAUSE FOR DENIAL OF APPOINTMENT OR CAUSE FOR WITHDRAWAL OF CLINICAL PRIVILEGES. ALL INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

By applying for clinical privileges and/or appointment to the medical staff, I make this ethical pledge that I will provide continuous care to my patients and will refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical, dental, or other practitioner who is not qualified to undertake this responsibility and who is not adequately supervised. I will seek consultation whenever necessary, will refrain from providing "ghost" surgical and/or medical services, and will refrain from fee splitting or other inducements to patient referral. I understand if I am in an administrative position desiring medical staff membership or clinical privileges, I am subject to the same procedures as all other applicants for membership or privileges. I will not conduct myself in a way that would discredit Brooke Army Medical Center (BAMC) and the US Army or bring adverse action against it.

(ACTIVE DUTY AND DAC ONLY) I will not conduct or assist in the practice of medicine, dentistry, or any other specialty at any institution other than BAMC, Fort Sam Houston, Texas, without the written consent of the Commander, BAMC. I understand that the requirements of DOD Directive 6025.13, AR 40-68, and HSC Reg 600-3 apply to all requests for outside employment.

In making application for appointment to the medical staff of BAMC, I affirm that I have been oriented to the bylaws and rules (appropriate Army Regulations and local regulations/policies) and agree to be bound by them as they are now written and as hereafter may be amended. I also hereby signify my willingness to appear for any interviews necessary in regard to my application.

I hereby release from liability any representative of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my request for privileges at BAMC, and I hereby release from liability any and all individuals and organizations who provide information to the hospital or its medical staff in good faith and without malice concerning my professional competence, ethics, character and other qualification for clinical privileges and/or staff appointment, and hereby consent to the release of such information.

Signature of Applicant

Date

Typed/Printed Name and Grade



DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

Physician

REPLY TO
ATTENTION OF

MCHE- _____ (40-68)

Date: _____

MEMORANDUM FOR Chairperson, Medical Staff Executive Committee, Brooke
Army Medical Center, Fort Sam Houston TX 78234-6200

SUBJECT: Request for Renewal of Medical Staff Appointment and Clinical
Privileges

1. I request renewal of my staff appointment and clinical privileges as delineated on the enclosed DA 5440 series.
2. I still possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and I am as clinically competent to perform in those areas as I was when I first applied for clinical privileges at this medical center.
3. I have developed no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.
4. If any change in my physical or mental state occurs during the privileging period, I will immediately, or as soon as physically able, notify a designated supervisor.
5. The following formation is furnished for review by the Medical Staff Executive Committee and will become a part of my permanent credentials file. Only those items that have not been regularly provided to the Credentials Office during the previous period are enclosed.
 - a. Proof of continuing medical education
 - b. Copy of current state licensure, showing expiration date (any/all current/lapsed licenses)
 - c. Copy of board certification (if certified/recertified since last request)
 - d. Copy of current BLS, ACLS, and/or ATLS certification
 - e. Copy of current, dated curriculum vitae (if changes since last submission)
 - f. DA Form 5754-R, Malpractice and Privileges Questionnaire

Encl

Signature

Typed/Printed Name/Rank

To the best of my knowledge the above information is correct.

Supervisor's Signature

Supervisor's Printed Name



DEPARTMENT OF THE ARMY
GREAT PLAINS REGIONAL MEDICAL COMMAND
FORT SAM HOUSTON, TEXAS 78234-6200

Allied Health

REPLY TO
ATTENTION OF

MCHE- _____ (40-68)

Date: _____

MEMORANDUM FOR Chairperson, Medical Staff Executive Committee, Brooke
Army Medical Center, Fort Sam Houston TX 78234-6200

SUBJECT: Request for Renewal of Clinical Privileges

1. I request renewal of my clinical privileges as delineated on the enclosed DA 5440 series.
2. I still possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and I am as clinically competent to perform in those areas as I was when I first applied for clinical privileges at this medical center.
3. I have developed no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.
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 - d. Copy of current BLS, ACLS, and/or ATLS certification
 - e. Copy of current, dated curriculum vitae (if changes since last submission)
 - f. DA Form 5754-R, Malpractice and Privileges Questionnaire

Encl

Signature

Typed/Printed Name/Rank

To the best of my knowledge the above information is correct.

Supervisor's Signature

Supervisor's Printed Name

**PRACTITIONER CREDENTIAL FILE
(PCF)**

SECTION I

Privilege Memorandum
DA Form 5440A, Delineation of Privileges Record
DA Form 5440-XX-R, Delineation of Privileges (Specialty)
DA Form 5754, Malpractice & Privileges Questionnaire
Request for Privileges Memorandum
DA Form 5441-XX-R, Evaluation of Privileges (Specialty)
DA Form 4691-R, Initial Application for Privileges

SECTION II

DA Form 5374-R, Performance Assessment

SECTION III

National Practitioner Data Bank (NPDB)
Letters of Notification/Acknowledgement
Hearing Summary or Minutes
Investigations
Adverse Statements
Malpractice Claims

SECTION IV

Continuing Medical Education (CME)
Curriculum Vitae/Resume (Lectures Given, Published Papers, Special Activities)

SECTION V

Copy of Orders
Credentials from Previous MTFs/Hospitals
Letters from Peers

SECTION VI

Proof of Malpractice Insurance
BLS/ACLS/ATLS/PALS/NPR
State License/Renewal Certificates
Federal/State Narcotics License
National Commission for Certification of Physician Assistants (NCCPA)
Specialty Board
Fellowship
Residency
Internship
ECFMG
Medical/Ph.D./Masters Degree
Bachelors/Registered Nurse Degree

Point of Contacts

Hannah Riceberg, Credentials Coordinator
Stephanie Courtney, Credentials Coordinator
Sylvia Liserio, Credentials Assistant

Phone: (210) 916-2460
Phone: DSN: 429-2460
FAX: (210) 916-5102
FAX DSN: 429-5102

Brooke Army Medical Center (BAMC)
ATTN: MCHE-PSQ, Credentials
3851 Roger Brooke Drive, Bldg 3600
Fort Sam Houston, Texas 78234-6200

CHCS Training
6-2405/6-3491
CPR Training Office 6-0351/3571