

DELINEATION OF PRIVILEGES RECORD For use of this form, see AR 40-68; the proponent agency is OTSG	1. PERIOD D TO
---	-------------------

2. Check the Appropriate Category

A. Anesthesia	I. Pediatrics	Q. Nurse Practitioners (<i>Adult</i>)
B. Dentistry	J. Podiatry	R. Nurse Practitioners (<i>Pediatric</i>)
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 (<i>Specify</i>)
G. Optometry Service	O. Nurse Anesthetists	
H. Pathology	P. Nurse Midwives	

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC IRWIN ARMY COMMUNITY HOSPITAL FORT RILEY, KS	B. STATUS <input type="checkbox"/> (1) Temporary <input type="checkbox"/> (2) Provisional <input type="checkbox"/> (3) Courtesy <input type="checkbox"/> (4) Consulting <input type="checkbox"/> (5) Full (<i>Appointment Status</i>)	C. CLINICAL PRIVILEGES <input type="checkbox"/> (1) Granted as Requested <input type="checkbox"/> (2) Modified as Recommended <input type="checkbox"/> (3) Other (<i>See Remarks</i>)	
D. DEPT./SVC (<i>Specify</i>)	E. DATE	G. CREDENTIALS COMMITTEE JON J. WILSON LTC, MC	H. DATE
F. SIGNATURE	I. SIGNATURE		

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER ARTHUR P. WALLACE COL, AN	B. SIGNATURE	C. DATE
--	--------------	---------

5. Remarks

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.

PRIVILEGE CATEGORY:

STAFF APPOINTMENT:

ADMITTING PRIVILEGES: ___ YES ___ NO

6. Practitioner's Education/Training Update

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

IRWIN ARMY COMMUNITY HOSPITAL (IACH)
CLINICAL PRIVILEGE APPLICATION INSTRUCTIONS

FORMS FOR COMPLETION:

NAME: _____

	1. DA Form 5440A-R (<u>Delineation of Privileges Record</u>): COMPLETE SECTION 6 ONLY of the form (Practitioner's Education/Training Update). Sign and date the form. Note "N/A" where not applicable.
	2. DA Form 5440-XX-R (<u>Delineation of Privileges</u>) for appropriate specialty. INITIAL each privilege you wish to request on the left hand side of each page and INITIAL category (if applicable to form). Mark "N/A" if you are not requesting a specific privilege. If Osteopathic Physician and you are requesting osteopathic manipulation privileges, "Osteopathic Manipulation" must be listed on the Delineation Form.
	3. DA Form 4691-R (<u>Initial Application for Clinical Privileges</u>): Form must be completed and reflect no lapses in time from the date qualifying degree was obtained. Complete through item 34B on reverse side.
	4. DA Form 5754-R (<u>Malpractice & Privileges Questionnaire</u>): If Active Duty Military, note "N/A" in items 11a, 11b, 12a, and 12b. Form must be completed in its entirety; sign and date the form. Section #12 must indicate all health care facilities where you hold clinical privileges.
	5. DA Form 5753-R (<u>USAR/ARNG Application for Clinical Privileges</u>): This form is only required for USAR/ARNG Health Care Providers requesting privileges to perform Active or Inactive Duty training.
	6. <u>Statement of Affirmation/Release of Information Form</u> : Read and complete bottom three lines.
	7. Memorandum Requesting Approval of Clinical Privileges and Medical Staff Appointment

DOCUMENTATION REQUIRED:

	1. Copy of orders (if Active Duty/USAR/ARNG).
	2. Copy of current certification in BLS/ACLS/ATLS/PALS. (Current certification in BLS is required for all providers; ACLS is required for EMS providers but does not meet requirement for BLS; ATLS & PALS are documented in the file, but do not fulfill requirement for BLS or ACLS; ATLS & PALS are required for primary EMS physicians.)
	3. Copies of all licenses - original license <u>and</u> wallet copy which indicates expiration date.
	4. Copy of DEA registration (if applicable).
	5. Copy of all diplomas.
	6. Copy of ECFMG certificate (if foreign medical graduate).
	7. Copy of all post-graduate training certificates.
	8. Copy of board certification certificates and sub-specialty board certificates (if applicable).
	9. Copy of all membership certificates (if applicable), i.e. AANA, NCCPA, AOTA, APTA, AMA, ADA.
	10. Reference letters from two peers (in your specialty) whom we may contact on your behalf. Peers must be individuals who are in a position to evaluate your professional standing, character and ability to perform privileges requested. Letters must include address and telephone number.
	11. Copy of current and dated Curriculum Vitae.
	12. Copy of malpractice insurance policy (if not AD/USAR/ARNG/DAC).

Comments:

If you have any questions or need assistance, please contact the Quality Management Office, Credentials Coordinator (Rosemary Morrow) at (785) 239-7155 or DSN 856-7155. At least thirty days should be allowed from the time all requested forms and documentation are received for privileging action to be completed.

Mailing Address: Commander, Irwin Army Community Hospital, ATTN: MCXX-MCD-QM (Credentials), 600 Caisson Hill Road, Fort Riley, KS 66442-5037.

PLEASE RETURN THIS DOCUMENT WITH YOUR APPLICATION.

DELINEATION OF PRIVILEGES RECORD

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

1. PERIOD
FROM _____ TO _____

2. Check the Appropriate Category

A. Anesthesia	I. Pediatrics	Q. Nurse Practitioners (<i>Adult</i>)
B. Dentistry	J. Podiatry	R. Nurse Practitioners (<i>Pediatric</i>)
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 (<i>Specify</i>)
G. Optometry Service	O. Nurse Anesthetists	
H. Pathology	P. Nurse Midwives	

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC IRWIN ARMY COMMUNITY HOSPITAL FORT RILEY, KS 66442-5037		B. STATUS <input type="checkbox"/> (1) Temporary <input type="checkbox"/> (2) Provisional <input type="checkbox"/> (3) Courtesy <input type="checkbox"/> (4) Consulting <input type="checkbox"/> (5) Full (<i>Appointment Status!</i>)		C. CLINICAL PRIVILEGES <input type="checkbox"/> (1) Granted as Requested <input type="checkbox"/> (2) Modified as Recommended <input type="checkbox"/> (3) Other (<i>See Remarks</i>)	
D. DEPT./SVC (<i>Specify</i>)	E. DATE	G. CREDENTIALS COMMITTEE	H. DATE		
F. SIGNATURE		I. SIGNATURE			

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER	B. SIGNATURE	C. DATE
--------------------------------------	--------------	---------

5. Remarks

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.

PRIVILEGE CATEGORY:

STAFF APPOINTMENT:

ADMITTING PRIVILEGES: ___ YES ___ NO

6. Practitioner's Education/Training Update

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

MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

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

DATA REQUIRED BY THE PRIVACY ACT 1974

Authority: Title 5, United States Code (USC), Sections 3109 and 3301. (Title 5, USC, Section 552a)
Principle Purpose: To obtain U.S. Civil Service appointment.
Routine Uses: Basis for determination of qualifications and background information for the eligibility for appointment. Basis or credentialing health care providers.
Disclosure: Disclosure of information requested 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 provider positions. As part of this process, please complete the following statements (as applicable to your profession).

1. NAME OF INDIVIDUAL		2. SOCIAL SECURITY NUMBER (SSN)	
HAVE (YES)	HAVE NOT (NO)	STATEMENTS	
		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. (If affirmative explain each incident in Item 13 below.)	
		4. I am licensed/registered/certified by the authority named in item 13 below. (List all current and past licenses held, include issue and expiration date. Explain the suspension or revocation of licensure previously held.)	
		5. Had my professional license denied, withdrawn or restricted voluntarily/involuntarily by a state or local licensing board or other authority. (If affirmative, give the organization name, address and dates involved in Item 13 below.)	
		6. Had professional privileges denied, withdrawn, or restricted voluntarily/involuntarily by a health care facility. (If affirmative, give the organization name, address, and dates involved in Item 13 below.)	
		7. Resigned or otherwise disassociated myself from employment or practice after being notified of intent to start action against me for failure to properly accomplish my professional responsibilities. (If affirmative, give organization name, address and dates involved in Item 13 below.)	
		8. Are you now or have you ever been required to appear before any medical or state regulating authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted practitioner? (If affirmative, give brief explanation in Item 13 below.)	
		9. Had a history of drug or alcohol abuse or misuse. (If affirmative, explain in Item 13 below.)	
		10. Do you have any disease or impairments which make your employment a hazard to yourself or other? (If affirmative, please list in Item 13 below.) In addition, please provide a brief description of your health status as it pertains to the privileges being requested.	
		11. I hereby authorize the U.S. Army to contact my current and previous malpractice carrier/licensing organizations for the purpose of verifying the above information.	
		11a. CARRIERS (Name and Address - current and previous)	11c. LICENSING ORGANIZATIONS (Name and Address current and previous)
		11b. Policy Number: _____	
		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:	
		12a. ORGANIZATION (Name and Address)	12b. DATE(S)
13. CLARIFICATIONS, EXPLANATIONS, ETC. REGARDING ITEMS 3-10 ABOVE. (Identify by appropriate number, continue on reverse if necessary.)			
14a. TYPED/PRINTED NAME OF APPLICANT		14b. SIGNATURE OF APPLICANT	14c. DATE



DEPARTMENT OF THE ARMY
USA MEDICAL DEPARTMENT ACTIVITY
600 CAISSON HILL ROAD
FORT RILEY, KANSAS 66442-5037

REPLY TO
ATTENTION OF

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 STAFF PRIVILEGES. ALL INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

By applying for appointment/reappointment to the medical staff, of Irwin Army Community Hospital, Fort Riley, Kansas, I make this ethical statement and 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 or dental 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 will not conduct or assist in the practice of medicine at any other institution unless specific approval is granted in writing by the Commander in accordance with applicable regulations.

I have been provided a summary defining the rules, regulations, and by-laws of Irwin Army community Hospital, Fort Riley, Kansas, as currently written or hereafter amended, pertaining to medical practice and agree to abide by the rules delineated therein. Moreover, I specifically pledge that I will not accept any compensation from patients, insurance companies or other sources for services rendered at Irwin Army Community Hospital, Fort Riley, Kansas. I pledge not to receive compensation from beneficiaries entitled to care by regulation regardless of where care and/or treatment is performed, nor will I accept compensation directly or indirectly from the federal government through outside employment. Should I receive such payment, I will release it to the Treasurer of the United States.

By applying for appointment/reappointment to the medical staff, I hereby signify my willingness to appear for interviews necessary in regard to my application. I hereby authorize the Commander, Credentials Committee, or their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, ethical and educational qualifications. I hereby further consent to release from any liability all individuals and organizations who provide information to Irwin Army Community Hospital, Fort Riley, Kansas or its medical staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information by said individuals and organizations, to include any adverse information deemed appropriate, to Irwin Army Community Hospital, Fort Riley, Kansas. A copy of this statement shall be as binding as the original.

DATE

SIGNATURE

PRINT FULL NAME/RANK

DATE OF BIRTH/SOCIAL SECURITY #

MCXX-MCD-QM (40-68)

(Date)

MEMORANDUM FOR Chairman, Credentials Committee, Irwin Army Community Hospital,
Fort Riley, KS 66442-5037

SUBJECT: Request for Clinical Privileges

1. I request approval of clinical privileges as specified on the enclosed DA Form 5440-series, Delineation of Privileges.
2. This request is accompanied by the documents required for the credentials review for clinical privileging.

Signature

Printed Name, Rank

MCXX-MCD-QM (40-68)

(Date)

MEMORANDUM FOR Chairman, Credentials Committee, Irwin Army Community Hospital,
Fort Riley, KS 66442-5037

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment

1. I request approval of clinical privileges as specified on the enclosed DA Form 5440-series, Delineation of Privileges, and medical staff appointment.
2. This request is accompanied by the documents required for the credentials review for clinical privileging.

Signature

Printed Name, Rank