



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
550 POPE AVENUE
FORT LEAVENWORTH, KANSAS 66027-2332



S:

MCXN-QMD (40-68a)

MEMORANDUM FOR

SUBJECT: Update of Credentials

1. In accordance with AR 40-68, Practitioner Credentials Files (PCFs) and Practitioner Activity Files (PAFs) must be established, maintained, and updated periodically to ensure that credential documents are kept current.

2. To establish/update your PCF and PAF, please provide the information/documents checked below:

- ___ Diploma from medical/dental school
- ___ ECFMG (if foreign graduate)
- ___ Internship certificate
- ___ Residency certificate
- ___ Fellowship certificate
- ___ Specialty board certificate
- ___ Evidence of current state license
- ___ Evidence of an original state license certificate
- ___ Controlled substances registration certificate from the Drug Enforcement Agency (DEA)
- ___ Dated Curriculum Vitae to account for ALL periods of time subsequent to obtaining your medical/dental degree
- ___ Two letters of reference from physicians qualified to evaluate your performance of work, including one from an official at the institution where you previously had or currently have clinical privileges. **MUST BE DATED WITHIN ONE YEAR**
- ___ Evidence of Certification in CPR
- ___ Evidence of training in Advance Cardiac Life Support, Advanced Trauma Life Support, and/or Pediatric Advanced Life Support (if applicable)
- ___ Proof of required malpractice insurance
- ___ Statement of current employment
- ___ Statement of current mental and health status
- ___ Attachments

EDITH L. COTTON
Credentials Coordinator



**DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
550 POPE AVENUE
FORT LEAVENWORTH, KANSAS 66027-2332**



REPLY TO
ATTENTION OF

MCXN-QMD

MEMORANDUM THRU Deputy Commander for Clinical Services

FOR Credentials Committee

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment

1. I request an appointment to the medical staff of Munson Army Health Center, Fort Leavenworth, KS and clinical privileges as specified on the enclosed DA Form 5440-series, Delineation of Privileges form.
2. This request is accompanied by the documents required for the credentials review for medical staff appointment and clinical privileging.

Provider Signature

DELINEATION OF PRIVILEGES RECORD		1. PERIOD	
For use of this form, see AR 40-88, the proponent agency is OTSG		FROM	TO
2. Check the Appropriate Category			
A. Anesthesia	I. Pediatrics	O. 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	B. STATUS *	C. CLINICAL PRIVILEGES	
		<input type="checkbox"/> (1) Granted as Requested <input type="checkbox"/> (2) Modified as Recommended <input type="checkbox"/> (3) Other (See Remarks)	
D. DEPT /SVC (Specify)	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

* Approved for _____ Privileges and _____ Appointment.

** Based upon my knowledge, I attest to the validity of this provider's personal description of his/her physical and mental status.

This provider (does/does not) have admitting privileges to this health center.

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

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 with 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 SOCIETY(IES) (Specify)		K. SIGNATURE	L. DATE

**RELEASE OF INFORMATION
AND
CONTINUOUS CARE PLEDGE**

By applying for clinical privileges at Munson Army Health Center (MAHC), I pledge that I will, to the maximum extent possible, provide continuous care to my patients and will refrain from delegating the responsibility for diagnosis or care of patients to another health care provider who is not qualified to undertake that responsibility and/or who is not adequately supervised.

I understand that clinical privileges are granted by the Commander of MAHC and are contingent upon me abiding by the rules, regulations and policies as currently written or as hereafter amended. This includes, but is not limited to, elements defined in Army Regulation 40-68, MEDDAC Regulation 40-50, Joint Commission on Accreditation of Health Care Organizations and the MACH Quality Assurance/Management Program. I have been given an opportunity to read the documents specified above, or acknowledge having been provided a copy of same.

I hereby release from any liability all representatives of Munson Army Health Center, Fort Leavenworth, Kansas its employees and members of the medical staff for their acts performed in good faith and without malice in connection with evaluation of my application for clinical privileges and review of my credentials. I also release from any liability any and all individuals and organizations who provide information to Munson Army Health Center, in good faith and without malice, concerning my competence, ethics, character and other qualifications for staff appointment and clinical privileges. This release includes otherwise privileged or confidential information concerning my education, training, experience, competency, licensure, board membership certification, continuing education, physical or mental status peer recommendations, malpractice history, past and current clinical privileges held and performed, assessments of clinical skills, ability and judgment, communication skills, rapport with patients and colleagues, professional or ethical conduct, and adherence to facility and departmental Quality Assurance/Management Programs, protocols and policies.

I understand that any significant misstatements or omissions from my application and any allied documents submitted therewith constitutes cause for denial of clinical privileges or withdrawal of clinical privileges. All information submitted in my application is true to the best of my knowledge.

_____ **Date**

_____ **Signature**

_____ **Date of Birth**

_____ **Printed Name**

A copy of this Release of Information and Continuous Care Pledge shall be as binding as the original.

CURRICULUM VITAE

NAME:

RANK:

SOCIAL SECURITY:

OBC DATE (Military):

HOME ADDRESS:

HOME PHONE:

DATE OF BIRTH:

PLACE OF BIRTH:

MARITAL STATUS:

SPOUSE (NAME):

CHILDREN:

EDUCATION

UNDERGRADUATE:

GRADUATE:

INTERNSHIP:

RESIDENCY:

CERTIFICATIONS:

PROFESSIONAL SOCIETIES:

PROFESSIONAL ASSIGNMENTS:

AWARDS:

PUBLICATIONS: