

<b>DELINEATION OF PRIVILEGES RECORD</b> <small>For use of this form, see AR 40-68; the proponent agency is OTSG</small>		1. PERIOD FROM _____ TO _____
<b>2. Check the Appropriate Category</b>		
A. Anesthesia	I. Pediatrics	D. 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/IDENTAC	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 (Appointment 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
F. SIGNATURE	H. DATE	
	I. SIGNATURE <b>RICHARD T. BEITZ, LTC, MC, DCCS/Chair</b>	

**4. Approval**

A. NAME OF HOSPITAL/IDENTAC COMMANDER	D. SIGNATURE	C. DATE
<b>RONALD J. JONES, COL, MC, Commanding</b>		

**5. Remarks**

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

# USAR OR ARNG APPLICATION FOR CLINICAL PRIVILEGES TO PERFORM ACTIVE OR INACTIVE DUTY TRAINING

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

### DATA REQUIRED BY THE PRIVACY ACT OF 1974

**Authority:** Title 5, United States Code (USC), Sections 301, Title 44, USC, Section 3101, and Title 10, USC, Section 1071.  
**Principal Purpose:** To define the extent and limits of the practitioner's clinical privileges as a function of his or her training experience.  
**Routine Uses:** Determine and assess capability of practitioner's clinical practice. A copy of this form will be retained in your credentials file. Information may be provided to certain civilian hospitals, the Federation of State Medical Boards of the U.S., State licensure authorities, and other appropriate professional regulating bodies.  
**Use of Data:** Disclosure of information requested is voluntary. However, failure to provide the required information may result in the limitation or termination of your clinical privileges.

### SECTION A - IDENTIFICATION

1. NAME (Last, first, middle)	2. SOCIAL SECURITY NO. (SSN)	3. DOB	4. GRADE
5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING	

### SECTION B - BASIC INFORMATION

8. LICENSURE/CPHT		9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure (if any)			
b. DEA Number (if any)			
c. CPH Certificate			
d. ACLS Certificate			
e. BCLS Certificate			
11. BOARD ELIGIBLE FROM (Date)	12a. BOARD EXAM TAKEN (Date)	12b. CHECK <input type="checkbox"/> Total <input type="checkbox"/> Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES (Specify)
13. BOARD CERTIFIED? (If yes, give name of Board(s)) <input type="checkbox"/> Yes <input type="checkbox"/> No			

#### 15. Current Hospital Privileges

a. NAME OF HOSPITAL	b. LOCATION	c. TYPE OF APPOINTMENT

#### 16. Interval Information (If Yes to any of the following questions, give full details on a separate sheet of paper.)

In the last year, have you:	YES	NO	h. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the Outpatient Clinic?	YES	NO
a. Have you had any final unfavorable liability judgments?			i. Would you feel comfortable and competent to perform your AD Training as a General Medical Officer in the Emergency Care area?		
b. If yes, any liability payments above \$100,000?				j. Do you certify that you are mentally and physically able to practice medicine?	
c. Have you been the subject of any disciplinary action by any local or state medical society or any licensing agency?			17. COMMENTS		
d. Have you had your clinical privileges limited, revoked, or otherwise modified at any institution?					
e. Resigned from the staff of any hospital?					
f. Been treated for drug or alcohol abuse?					
g. Not maintained your state's continuing medical education requirements?					

The information contained herein is true to the best of my knowledge and belief.

18a. SIGNATURE OF APPLICANT

18b. DATE

**SECTION C - ARNG OR USAR UNIT COMMANDER'S RECOMMENDATIONS**

That clinical privileges be granted to the named applicant for Active or Inactive duty.				1 NAME			
2 PERIOD				3 MEDICAL TREATMENT FACILITY OR DENTAC			
FROM	TO						
4 BY EDUCATION AND TRAINING THIS PRACTITIONER IS QUALIFIED IN THE FOLLOWING				5 PRACTITIONER'S DEMONSTRATED CLINICAL COMPETENCY REMARKS			
SPECIALTIES			UN-KNOWN			YES	NO
a.	Primary →		/				
b.	Secondary →		/				
6	This practitioner has the capability of performing the medical duties required of a General Medical Officer or General Dentist						
7.	All documents of education, training, licensure/certification/registration and ECFMG (if applicable) have been verified with a primary source		/				
8a NAME OF VERIFYING INDIVIDUAL			8b GRADE		8c SIGNATURE		
8c TITLE			8d DATE				
9a NAME OF UNIT COMMANDER			9b GRADE		9c SIGNATURE		
9c TITLE			9d DATE				

**SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE**

10 REMARKS	11 RECOMMENDED STATUS <input type="checkbox"/> Conditional <input type="checkbox"/> Full	
	12 CLINICAL PRIVILEGES RECOMMENDED <input type="checkbox"/> As Requested <input type="checkbox"/> Other (Specify in item 12)	
	13a NAME OF CREDENTIALS COMMITTEE CHAIR	13b GRADE
	13c SIGNATURE	13d DATE

**SECTION E - APPROVING AUTHORITY**

14a NAME OF MTF OR DENTAC COMMANDER	14b SIGNATURE	14c DATE
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## STATEMENT OF APPLICANT

(Please read carefully before signing)

All information submitted by me in this application is true to my best knowledge and belief. I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff.

In making this application for appointment to the medical staff of this hospital, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments, to accept consultation assignments and to participate in staffing the emergency service area and other special care units.

By applying for appointment to the medical staff I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the hospital, its medical staff and their representatives to consult with administrators and members of the 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 and ethical qualifications. I hereby further consent to the inspection by the hospital, its medical staff and its representatives of all documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any 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 qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize the hospital to communicate to other hospitals and to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics that the hospital may have or acquire, and where such communication is made in good faith and without malice, and I consent thereto to agree to hold the hospital and its authorized representatives free of liability therefor.

I understand and agree that I, as an applicant for medical staff membership or privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I particularly agree to subject my clinical performance to, and faithfully participate in, the hospital's quality assurance programs as the same shall from time to time be in effect, and I agree to hold members of the medical staff and other authorized representatives of the hospital engaged in these quality assurance activities free of all liability for their actions performed in good faith in connection therewith.

DATE

SIGNATURE OF APPLICANT

## MALPRACTICE AND PRIVILEGES QUESTIONNAIRE

For use of this form, see AR 40-88, 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 for 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.)			
#4. List all current and past licenses ever held. Include issue and expiration date.			
#10. Please provide a brief description of your health status as it pertains to the privileges being requested.			
14a. TYPED/PRINTED NAME OF APPLICANT		14b. SIGNATURE OF APPLICANT	14c. DATE