

IRWIN ARMY COMMUNITY HOSPITAL (IACH)
CLINICAL PRIVILEGE APPLICATION INSTRUCTIONS

FORMS FOR COMPLETION:

NAME: _____

	1. DA Form 5440A (<u>Approval of Clinical Privileges/Staff Appointment</u>): Fill out only 1-3 and 5 of this form. The remainder of this form will be completed by the Credentials Office. DO NOT write anywhere else on the form.
	2. DA Form 4691 (<u>Application for Initial Clinical Privileges and Staff Appointment</u>): Complete all portions of this form. If any part of the form does not apply to you, mark it "N/A".
	3. DA Form 5440-XX (<u>Delineation of Clinical Privileges</u> for appropriate specialty). Read the instructions carefully and thoroughly and complete form using the appropriate Provider Codes as directed. Mark "N/A" next to privileges not being requested. Write in privileges being requested if not on form, i.e., manipulative therapy privileges for D.O.
	4. DA Form 5754 (<u>Malpractice History and Clinical Privileges Questionnaire</u>): Form must be completed in its entirety; sign and date the second page of form. Please use your INITIALS in boxes, not check marks. If any part does not apply to you, mark it "N/A".
	5. DA Form 5753 (<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. DD Form 577 (<u>Signature Card</u>): Complete blocks 1, 2, 3, and sign block 5.

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 and OR 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 all primary EMS physicians.)
	3. Copies of all (active and inactive) licenses - original license and wallet copy which indicates expiration date.
	4. Copy of current DEA registration.
	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. References: Must be in writing with address and telephone number provided, dated within six months, and attest to current (within last year) clinical competence. Two references are required. One must be from a peer in a position to evaluate your professional standing, character, and ability to perform privileges requested. Non-physicians must provide at least one reference from a physician supervisor or a physician director of a training program completed within the last year.
	11. Copy of current and dated Curriculum Vitae.
	12. Copy of malpractice insurance policy (contract providers only). History of all malpractice claims.
	13. Copies of all CME certificates during past 12 months, or time period directed by Credentials Office.

Comments:

If you have any questions or need assistance, please contact the Quality Management Office, Credentials Coordinator 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-CR (Credentials), 600 Caisson Hill Road, Fort Riley, KS 66442-5037.

PLEASE RETURN THIS DOCUMENT WITH YOUR APPLICATION.

APPROVAL OF CLINICAL PRIVILEGES/STAFF APPOINTMENT

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

1. NAME OF PROVIDER <i>(Last, First, MI)</i>		2. RANK/GRADE	3. SSAN	4. EFFECTIVE PERIOD <i>(YYYYMMDD)</i> FROM _____ TO _____	
5. PRIVILEGES REQUESTED. <i>(Specify discipline(s))</i>					
a. Aerospace medicine	k. Neurology			u. Physician assistant	
b. Anesthesia	l. Nurse anesthesia			v. Podiatry	
c. Audiology	m. Nurse midwifery			w. Psychiatry	
d. Chiropractic	n. Nurse practitioner			x. Psychology	
e. Clinical pharmacy	o. Obstetrics and gynecology			y. Radiology/Nuclear medicine	
f. Dentistry	p. Occupational therapy			z. Social work	
g. Dietetics	q. Optometry			aa. Speech pathology	
h. Emergency medicine	r. Pathology			ab. Surgery	
i. Family practice	s. Pediatrics			ac. Other (specify)	
j. Internal medicine	t. Physical therapy				
6. RECOMMENDATIONS. The following department/service and credentials committee recommendations are based on a review of the provider's verified licensure, education and training, experience, physical and mental capabilities to perform the requested privileges and demonstrated current competence. Exceptions or stipulations are noted below in block 7.					
a. MEDICAL TREATMENT FACILITY/DENTAC <i>(Name and location)</i> IRWIN ARMY COMMUNITY HOSPITAL 600 CAISSON HILL ROAD FORT RILEY, KS 66442-5037		b. APPOINTMENT STATUS <input type="checkbox"/> Initial <input type="checkbox"/> None <input type="checkbox"/> Active <input type="checkbox"/> Affiliate <input type="checkbox"/> Temporary		c. CATEGORY OF PRIVILEGES <input type="checkbox"/> Regular <input type="checkbox"/> Supervised <input type="checkbox"/> Temporary	
d. ADMITTING PRIVILEGES <input type="checkbox"/> Requested <input type="checkbox"/> Granted <input type="checkbox"/> Not requested <input type="checkbox"/> Not granted		e. PLAN OF SUPERVISION <input type="checkbox"/> Required <input type="checkbox"/> Not required		f. NAME OF SUPERVISOR <i>(If applicable)</i>	
g. AGE GROUPS: <i>(Check all that apply.)</i> <input type="checkbox"/> Neonates (Birth - 28 days) <input type="checkbox"/> Infants (1-24 mos) <input type="checkbox"/> Children (2-12 yrs) <input type="checkbox"/> Adolescents (13-17 yrs) <input type="checkbox"/> Young Adults (18-23 yrs) <input type="checkbox"/> Adults (24-65 yrs) <input type="checkbox"/> Geriatrics (> 65 yrs)					
h. DEPARTMENT/SERVICE CHIEF <i>(Typed name and title)</i>		i. SIGNATURE		j. DATE <i>(YYYYMMDD)</i>	
k. The credentials committee met on _____ to review the merits of this provider's application for staff appointment and/or clinical privileges. It is the decision of this committee to <input type="checkbox"/> CONCUR <input type="checkbox"/> NOT CONCUR with the above recommendations. Exceptions or stipulations are noted below in block 7.					
l. CREDENTIALS COMMITTEE CHAIRPERSON <i>(Name and rank)</i>		m. SIGNATURE		n. DATE <i>(YYYYMMDD)</i>	
7. REMARKS					
8. The Executive Committee of the Medical/Dental Staff (ECMS/ECDS) reviewed this provider's request for privileges and medical staff appointment, as applicable, on _____. It is the decision of this committee to <input type="checkbox"/> CONCUR <input type="checkbox"/> NOT CONCUR with the above recommendations.					
8a. ECMS/ECDS CHAIRPERSON <i>(Name and rank)</i>		8b. SIGNATURE		8c. DATE <i>(YYYYMMDD)</i>	
9. APPROVAL. Based on my review of the information submitted in support of the provider's licensure, education and training, and his/her demonstrated competence, privileges are approved and medical staff membership is awarded as requested. The period for which clinical privileges and staff membership are in effect is as noted above in Block 4.					
9a. NAME OF HOSPITAL/DENTAC COMMANDER		9b. COMMANDER'S SIGNATURE		9c. DATE <i>(YYYYMMDD)</i>	

APPLICATION FOR INITIAL CLINICAL PRIVILEGES AND STAFF APPOINTMENT

(For use of this form, see AP 40-68; the proponent agency is OTSG.)

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.
Principal Purpose: To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.
Routine Uses: To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.
Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all providers (military/civilian) who are first time applicants for clinical privileges and for initial medical staff appointment, if requested. Initial staff appointment is granted on the occasion of the provider's first assignment/employment at a DoD MTF, or if there has been a lapse in DoD MTF appointment status of greater than 180 days, e.g., the provider has been involved in civilian training program.

SECTION I - IDENTIFICATION

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH <i>(YYYYMMDD)</i>
5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY <i>(Name and Address: City/State/Zip Code)</i> IRWIN ARMY COMMUNITY HOSPITAL, FORT RILEY, KS 66442-5037		

SECTION II - PROFESSIONAL EDUCATION

7a. COLLEGE OR UNIVERSITY	7b. LOCATION <i>(City/State)</i>	7c. DEGREE	7d. GRADUATION DATE <i>(YYYYMMDD)</i>

SECTION III - POSTGRADUATE TRAINING

8a. HOSPITAL OR INSTITUTION	8b. LOCATION <i>(City/State)</i>	8c. PROGRAM <i>(Residency)</i>	8d. COMPLETION DATE <i>(YYYYMMDD)</i>

SECTION IV - PREVIOUS PROFESSIONAL AFFILIATIONS *(Past 10 years. Continue on reverse in block 23.)*

9a. HOSPITAL OR INSTITUTION	9b. LOCATION <i>(City/State)</i>	9c. FROM/TO <i>(YY/MM-YY/MM)</i>	9d. DEPARTMENT

SECTION V - BOARD CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

10. Are you eligible to take your board examination? N/A NO YES *(If YES, indicate specialty in block 22.)*

11. Have you taken your boards? NO YES *(If YES, note date.)* _____ TOTAL PARTIAL

12. Are you ABMS board certified? NO YES *(If YES, indicate specialty in block 23.)*

13. Memberships in Specialty Societies. *(List all active memberships.)*

SECTION VI - LICENSURE/CERTIFICATION/REGISTRATION. (Include all current and previous states of licensure.)

14a. STATE OR AUTHORIZING AGENCY	14b. LICENSE NUMBER	14c. EXPIRATION DATE (YYYYMMDD)

SECTION VII - CONTROLLED SUBSTANCES REGISTRY

15a. DEA OR CDS NUMBER	15b. STATE OF ISSUE (If applicable)	15c. EXPIRATION DATE (YYYYMMDD)

SECTION VIII - CLINICAL PRIVILEGES REQUESTED

16. I attest that based on my professional qualifications and credentials, I am clinically competent to fully perform the clinical privileges for which I am applying. I request privileges in the following disciplines:

17. I request privileges in the following category: (Check one.) <input type="checkbox"/> Regular <input type="checkbox"/> Temporary <input type="checkbox"/> Supervised	18. I request admitting privileges. <input type="checkbox"/> YES <input type="checkbox"/> NO
19. I request to manage and treat patients in age groups: (Check all that apply.) <input type="checkbox"/> Children (2-12 yrs) <input type="checkbox"/> Adolescents (13-17 yrs) <input type="checkbox"/> Young Adults (18-23 yrs) <input type="checkbox"/> Adults (24-65 yrs) <input type="checkbox"/> Neonates (Birth - 28 days) <input type="checkbox"/> Infants (1-24 mos) <input type="checkbox"/> Geriatrics (> 65 yrs)	

SECTION IX - STAFF APPOINTMENT REQUESTED

20. I request initial appointment to the medical/dental staff of this health care facility. YES NO

SECTION X - OTHER

21. Do you possess ECFMG certification? N/A NO YES (If YES, note date of issue.) _____

22. Which of the following do you possess? (Check all that apply.) BLS ACLS ATLS PALS Other (specify) _____

SECTION XI - COMMENTS

23. Provide explanation or additional details for any of the numbered items above. (Note item number.)

24. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge.

24a. SIGNATURE OF PROVIDER	24b. DATE (YYYYMMDD)
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MALPRACTICE HISTORY AND CLINICAL PRIVILEGES QUESTIONNAIRE

(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 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.
Principal Purpose: To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.
Routine Uses: To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.
Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all health care providers (military/civilian) upon initial entry or re-entry into Federal Service, and as part of the periodic clinical privileges renewal process.

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH <i>(YYYYMMDD)</i>
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5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY <i>(Name and Address: City/State/Zip Code)</i> IRWIN ARMY COMMUNITY HOSPITAL, FORT RILEY, KS 66442-5037
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7. Place a check (X) in the column that corresponds to your answer to each of the following questions. *(Any "YES" answer must be fully explained on the bottom of this page in block 8.)* Note: An answer is required for every question.

YES	NO	ARE YOU NOW OR HAVE YOU EVER:
		a. 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 provider?
		b. Had a history of alcohol or other drug abuse or misuse?
		c. Had your narcotics registration suspended or revoked?
		d. Had your professional privileges voluntarily or involuntarily denied, revoked, suspended, reduced, or restricted by a health care facility?
		e. Had your request for any specific clinical privilege(s) denied or granted with specific limitations?
		f. Voluntarily or involuntarily resigned or otherwise disassociated yourself from employment or practice after being notified of the intent to initiate action against you for failure to properly execute your professional responsibilities?
		g. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard professional practice?
		h. Had your professional license voluntarily or involuntarily denied, restricted, withdrawn, suspended, or revoked by a State or local licensing board or other authority?
		i. Been asked to voluntarily surrender your license?
		j. Had a previously successful or currently pending challenge(s) to any license or registration (e.g., State or District, Drug Enforcement Agency, etc.) that you hold now, or have held?
		k. Been refused membership in an institution's medical or dental staff?
		l. Been denied membership, or renewal thereof, or been subject to disciplinary action in any medical/dental organization?
		m. Been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance programs (i.e., Medicare or Medicaid)?
		n. Had your professional liability coverage canceled, limited, denied, or not renewed?

8. **COMMENTS.** Note item by number (7a. - 7n.) and provide clarification of any question with a "YES" answer. Include clarification for any circumstance not already addressed in detail on a previous DA Form 5754. *(Continue on a separate page.)*

9. HEALTH STATUS. Provide a brief description of your current physical and mental health status and your ability to perform the clinical privileges appropriate to your discipline.

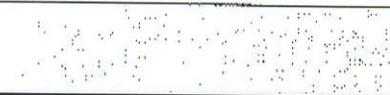
10. MALPRACTICE INSURANCE. Initial applicants address past 10 years, all others list only current carriers.

10a. CARRIER <i>(Current and previous)</i>	10b. ADDRESS <i>(Street/City/State/ZIP Code)</i>	10c. POLICY NUMBER

11. CLINICAL PRIVILEGES. Initial applicants address past 10 years, all others list the hospitals/institutions where privileges are currently held.

11a. HOSPITAL/INSTITUTION	11b. ADDRESS <i>(Street/City/State/ZIP Code)</i>	11c. FROM/TO <i>(YYYY-MM-YYYY)</i>

12. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge. I hereby authorize the U.S. Army to contact the malpractice carriers and the hospitals/institutions listed above for the purpose of verifying the information provided.

	12a. SIGNATURE OF PROVIDER	12b. DATE <i>(YYYYMMDD)</i>
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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 # _____

PEER RECOMMENDATION

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

SUBJECT: Peer Recommendation for Clinical Privileges

1. The undersigned is a peer of _____,
who is seeking clinical privileges.

2. I have had the opportunity to observe his/her:
 - a. performance in this specialty, and in my judgement the health care standards of practice expected of a clinician in that specialty are **EXCEEDED / MET / NOT MET**.

 - b. apparent emotional and physical health, and in my judgement, it is **EXCELLENT / GOOD / FAIR / POOR** and **HAS / DOES NOT HAVE** an adverse affect on this provider's clinical practice.

3. To my knowledge this health care provider:
 - a. **HAS / DOES NOT HAVE** sufficient experience to perform in this specialty.

 - b. **HAS / HAS NOT** actively pursued continuing medical education opportunities.

 - c. **HAS / HAS NOT** fulfilled medical staff obligations in a satisfactory manner.

4. This recommendation is made voluntarily and without reservation.

5. ADDITIONAL COMMENTS: _____

Signature

Name, Rank, Corps

Phone Number

Date

PEER RECOMMENDATION

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

SUBJECT: Peer Recommendation for Clinical Privileges

1. The undersigned is a peer of _____,
who is seeking clinical privileges.

2. I have had the opportunity to observe his/her:
 - a. performance in this specialty, and in my judgement the health care standards of practice expected of a clinician in that specialty are **EXCEEDED / MET / NOT MET**.

 - b. apparent emotional and physical health, and in my judgement, it is **EXCELLENT / GOOD / FAIR / POOR** and **HAS / DOES NOT HAVE** an adverse affect on this provider's clinical practice.

3. To my knowledge this health care provider:
 - a. **HAS / DOES NOT HAVE** sufficient experience to perform in this specialty.

 - b. **HAS / HAS NOT** actively pursued continuing medical education opportunities.

 - c. **HAS / HAS NOT** fulfilled medical staff obligations in a satisfactory manner.

4. This recommendation is made voluntarily and without reservation.

5. ADDITIONAL COMMENTS: _____

Signature

Name, Rank, Corps

Phone Number

Date

CURRICULUM VITAE
(SAMPLE)

FULL NAME:

SSN:

RANK:

DOB:

POB:

CURRENT ADDRESS AND PHONE:

HOME ADDRESS AND PHONE:

MARITAL AND FAMILY STATUS:

EDUCATION/TRAINING:

UNDERGRADUATE:

GRADUATE:

INTERNSHIP:

RESIDENCY:

FELLOWSHIP:

CERTIFICATIONS: (specialty board w/exp. date; BLS, ACLS, etc.)

PROFESSIONAL ASSIGNMENTS:

PROFESSIONAL SOCIETY MEMBERSHIPS:

AWARDS:

PUBLICATIONS:

SAMPLE

1. NAME <i>(Type or print)</i>	2. PAY GRADE	3. DATE
SSN		
4. OFFICIAL ADDRESS IRWIN ARMY COMMUNITY HOSPITAL FORT RILEY, KS 66442-5037		
5. SIGNATURE		
6. TYPE OF DOCUMENT OR PURPOSE FOR WHICH AUTHORIZED DD 1289		
THE ABOVE IS THE SIGNATURE OF THE AUTHORIZED INDIVIDUAL		
7. NAME OF COMMANDING OFFICER <i>(Type or Print)</i>	8. PAY GRADE	
9. SIGNATURE OF COMMANDING OFFICER		

DD Form 577, MAY 88

*Previous edition may
be used until exhausted*

SIGNATURE CARD

USAPA V1.00