MCXV-QI-CR 9 SEP 99

MEMORANDUM FOR Credentials Committee

SUBJECT: Acknowledgement of Understanding of DOD Policy on Physician Licensure

1. Since 1988, under 10 USC 1094 (and currently DoD Directive 6025.13, "Clinical Quality Management Program in the Military Health Services System," July 20, 1995), the Department of Defense (DoD) has required all physicians to have a medical license to practice. However, some States have permitted military physicians to be licensed in special licensure categories that waive certain requirements (such as standard license fees) and include restrictions on the scope of practice (such as limited to federal facilities). Section 1094 was amended by section 734 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, Pul. L. 104-261. The amendment takes effect October 1, 1999. The law now provides (with the amendment shown in italics):

a. (a)(1) A person under the jurisdiction of the Secretary of a military department may not provide health care independently as a health care professional under this chapter unless the person has a current license to provide such care. *In the case of a physician, the physician may not provide health care as a physician under this chapter unless the current license is an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by a jurisdiction that granted the license.*

b. (2) The Secretary of Defense may waive paragraph (1) with respect to any person in unusual circumstances. The Secretary shall prescribe by regulation the circumstances under which such a waiver may be granted.

2. In implementing this law, DoD policy is guided by a commitment to achieve, and assure the public that we achieve, an unsurpassed standard of quality medical care. DOD and MEDCOM implementation shall adhere to the following policies:

a. Unrestricted license. Any physician license in a licensure category that restricts the physician to practice in a federal facility or within some other confined limits does not comply with the requirement for an "unrestricted license." Unless waived, all physicians must have at least one current, unrestricted license. Physicians may hold additional licenses from States in licensure categories that have practice restrictions associated with military exemptions from certain fees or other requirements as long as the physician also holds at least one license for which there are no limitations on the scope of practice. Effective October 1, 1999, a physician without a full-scope license may not provide health care as a physician, unless a waiver is granted under this policy.

b. No waiver of clinical competency standards. A licensure category that includes limitations on scope of practice shall not be considered for a waiver of the unrestricted license requirement unless it includes all the same requirements pertaining to clinical competency (e.g.

education, training, tests, continuing medical education, investigation and sanction authority of the licensure board) as the full scope category and has no restrictions pertaining to clinical competency (e.g., practice under supervision). A waiver shall be considered only if the differences between the full scope license and limited scope license are solely of an administrative or financial nature.

c. Waiver possible for administrative or financial requirement inharmonious with federal policy. The statute permits a waiver of the unrestricted scope requirement only in "unusual circumstances." A requirement to pay the standard license fee associated with an unrestricted license is not an unusual circumstance and is not a basis for use of the waiver authority. A waiver may be considered in cases in which the administrative or financial requirements applicable to the full scope license that are not applicable to the limited scope license are substantial and seek to achieve a State purpose clearly inapplicable to military physicians based on federal policy. Examples of this would be a requirement that the physician reside in the State (federal policy calling for world-wide service), pay a substantial amount into a medical injury compensation fund (federal policy provides for medical injury compensation under federal statutes), or maintain private malpractice liability insurance (federal policy provides for malpractice liability through the U.S. treasury).

d. Careful review process to facilitate implementation consistency. Waiver consideration shall be based on a two-step process. First, the Assistant Secretary of Defense (Health Affairs) shall determine based on a review of a State's licensure requirements that the standard outlined in paragraphs 2 and 3 above are met and identify the particular State administrative or financial requirements that may be considered for waiver. Requests for this determination may be made by a Surgeon General. The Risk Management Committee shall consider such requests and make recommendations to the ASD(HA). Step two of the process shall be that individual physicians who do not hold a full scope license in any State but who hold a limited scope license in a State for which a waiver may be considered based on the step one determination may request a waiver from the Surgeon General of the Service involved. The request must include a justification for the waiver in the case of the individual physician. A waiver would not be granted for longer than the applicable time period of licensure; a subsequent licensure renewal would require a new waiver. The Surgeons General shall submit to the ASD(HA) an annual account of the waivers granted and the applicable justifications.

3. My signature below indicated acknowledgement and compliance with the licensure policy.

_____

Printed Name (Last, First, MI) (Rank/Status)

_____

(Signature and Date)

BAYNE-JONES ARMY COMMUNITY HOSPITAL
FORT POLK, LA 71459-5110

## APPLICATION CHECKLIST

ITEMS NEEDED (ALL CREDENTIALS MUST BE PRIME SOURCE VERIFIED)

_____ COPY OF DIPLOMAs/ PROFESSIONAL DEGREES

_____ COPY OF INTERNSHIP/RESIDENCY CERTIFICATE (if applicable)

_____ COPY OF PROFESSIONAL LICENSE/CERTIFICATION

_____ ECFMG CERTIFICATES (if APPLICABLE)

_____ COPY OF FEDERAL DEA & STATE

_____ COPY OF BLS, ACLS , PAL Certification (s)
_____ BLS MANDATORY )

_____ COPY OF BOARD CERTIFICATION FOR SPECIALTY

_____ PROOF OF CME FOR LAST THREE (3) YEARS

_____ NATIONAL PRACTITIONER DATA BANK QUERY

_____ PEER RECOMMENDATIONS (3) from same specialty

_____ VERIFICATION OF PRIVILEGES GRANTED FROM EACH PRIOR PLACE OF EMPLOYMENT

_____ COPIES OF RESULTS OF CRIMINAL BACKGROUND CHECK

_____ REQUEST FOR FEDERAL BACKGROUND CHECK

_____ DA FORM 5440-A

_____ DA FORM 5440-XX- R – DELINEATIONS OF PRIVILEGES

_____ DA FORM 4691 – APPLICATION FOR INITIAL CLINICAL PRIVILEGES

DA FORM 5754 – MALPRACTICE HISTORY AND CLINICAL PRIVILEGES QUESTIONNAIRE

_____ STATEMENT OF AFFIRMATION/RELEASE

_____ CURRENT CV

_____ MALPRACTICE INSURANCE EXP DATE:_____

_____ NPDB INFORMATION

_____ VITAL STATISTICS IF NO CV

_____ HOSPITAL DIRECTORY

_____ PROVIDER PERSONNEL PROFILE

_____ HEALTHCARE PROVIDER INFORMATION SHEET

**DEPARTMENT OF THE ARMY**
US ARMY MEDICAL DEPARTMENT ACTIVITY
1585 THIRD STREET
FORT POLK, LOUISIANA 71459-5110

MCXV-QI-CR

_____
(DATE)

MEMORANDUM FOR Chairperson, Credentials Committee, Bayne-Jones Army Community Hospital, Fort Polk, Louisiana 71459-5110

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment

1. I request an appointment to the medical staff of Bayne-Jones Army Community Hospital and clinical privileges as delineated on the enclosed DA Form 5440 series, Delineation of Privileges.

2. This request is accompanied by the documents required for the credentials review for medical staff appointment and clinical privileging.

3. I certify that I possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on Da Form 5440 series, and that I am clinically competent to perform in those areas.

4. I agree to provide any documentation which is determined to be missing or lapsed from my credentials file upon request from the Credentials Coordinator.

5. I agree to attend all required hospital training, meetings, and professional development activities.

_____
(SIGNATURE)

**APPLICATION FOR REQUEST FOR WAIVER OF ADMINISTRATIVE LICENSURE REQUIREMENTS**

NAME:_____ RANK_____
(Last) (First) (MI)

SSN_____

MTF_BAYNE-JONES ARMY COMMUNITY HOSPITAL_ Department/Service_____

RMC_____GREAT PLAINS REGIONAL MEDICAL COMMAND_____

**INSTRUCTIONS:** Check ONE of the following 2 paragraphs to identify your request:

A._____I am applying for a waiver of the following administrative licensure requirement (**CHECK ONE**). I understand that these have already been considered by ASD(HA) and are eligible for waiver if requested. Upon renewal of this license, I must submit another request for waiver.

_____Florida: Malpractice insurance and Neurological Injury Compensation Association (NICA) = risk pool
_____Kansas: Malpractice insurance and Healthcare Stabilization Fund (risk pool)
_____Massachusetts: Malpractice insurance
_____Oregon: Actual practice within the state
_____Pennsylvania: Malpractice insurance and Medical Professional Liability Catastrophe Loss Fund (CAT Fund) = risk pool
_____Colorado: Malpractice Insurance
_____Any state with mandated residencies or instate patient practice requirements
*Must submit support documents to Headquarters, US Army Medical Command (USAMEDCOM)

B._____I am licensed in a state that has an administrative requirement that is unusual, substantial, or inharmonious with federal policy not included on the above list. I am submitting a request for waiver of the following licensure requirement (**DESCRIBE IN SPACE PROVIDED BELOW AND SUBMIT SUPPORTING DOCUMENTATION).** I understand that reasonable exceptions to the state/conditions as identified in A will be forwarded to the Office of the Surgeon General, USAMEDCOM for review. If it is determined the request for exception has merit, it will be submitted to Assistant Secretary of Defense for Health Affairs (ASD{HA}) for consideration. If approved, a waiver will be granted. I understand that I must resubmit my request for waiver with the renewal of the license.

_____
_____
_____
_____

C. Signature of Applicant:_____ Date:_____

D. **MTF/Commander's Actions:**

1. _____The request for waiver meets the criteria identified in para A. Encl 2

Waiver APPROVED/NOT APPROVED

_____

Signature of approval authority (Date)

2. _____ The request for waiver request meets an unusual circumstance as described in para B.

Has authority to approve a request for the waiver as described been delegated to the MTF?

YES_____ Waiver APPROVED_____

NO_____ Forward request for waiver through RMC to MEDCOM.

_____

Signature of approval authority (Date)

3. Administrative

Waiver approval entered in CCQAS_____

By (Date)

Waiver approval reported to MEDCOM_____

By (Date)

# HEALTHCARE PROVIDER INFORMATION SHEET

Information on this sheet is used for Risk Management purposes only.

a. Name (Last, First, Middle Initial) _____

b. SSN _____-_____-_____ c. Date of Birth (YYYYMMDD) _____

d. Name of Professional School Attended _____

e. Date Graduated (YYYYMMDD) _____

f. Status

| | | | | |
|---|---|---|---|---|
| ☐ Army | ☐ Air Force | ☐ Civilian GS | ☐ Partnership External | ☐ Non- Personal Services Contract |
| ☐ Navy | ☐ PHS | ☐ Partnership Internal | ☐ Personal Services Contract | |

g. Source of Accession (x all that apply):

| (1) Military | | (2) Civilian | |
|---|---|---|---|
| ☐ Volunteer | ☐ National Guard | ☐ Civil Service | ☐ Consultant |
| ☐ Armed Forces Health Professional Scholarship Program | ☐ Reserve | ☐ Contracted | |
| ☐ Uniformed Services University of Health Sciences | ☐ Other (*Specify*) | ☐ Other (*Specify*) | |

h. Licensing Information:

| (1) State of License | (2) License Number | (1) State of License | (2) License Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

i. Type of Practitioner and Specialty (Field of Licensure) (X all that apply):

(1) Physician Degree: ☐ M.D. ☐ D.O.

| (2) Highest Level of Specialization | ☐ Board Certified | ☐ Residency Completed | ☐ In Residency | ☐ No Residency |
|---|---|---|---|---|

(3) Primary Specialty

| | | | |
|---|---|---|---|
| ☐ In Training | ☐ Internal Medicine (cont.) | ☐ Pathology | ☐ Surgery, General (Cont.) |
| ☐ General Practice (GMO) | ☐ Pulmonary | ☐ Pediatrics | ☐ Peripheral Vascular |
| ☐ Anesthesiology | ☐ Rheumatology | ☐ Physical Medicine | ☐ Plastic |
| ☐ Aviation Medicine | ☐ Tropical Medicine | ☐ Preventive Medicine | ☐ Underseas Medicine |
| ☐ Dermatology | ☐ Allergy/Immunology | ☐ Psychiatry | ☐ Urology |
| ☐ Emergency Medicine | ☐ Cardiology | ☐ Radiology | ☐ Intensivist |
| ☐ Family Practice | ☐ Endocrinology | ☐ Surgery, General | ☐ Neonatologist |
| ☐ Internal Medicine | ☐ Neurology | ☐ Cardio-Thoracic | ☐ Other (*Specify*) |
| ☐ Gastroenterology | ☐ Obstetrics/Gynecology | ☐ Colon-Rectal | |
| ☐ Hematology-Oncology | ☐ Ophthalmology | ☐ Neurosurgery | ☐ Oral Surgeon |
| ☐ Infectious Disease | ☐ Otorhinolaryngology | ☐ Oncology | |
| ☐ Nephrology | ☐ Orthopedics | ☐ Pediataric | |

| (4) Board Certification (s) | _____ |
|---|---|
| | _____ |

(5) Other Practitioners:

| | | | |
|---|---|---|---|
| ☐ Audiologist | ☐ Nurse Anesthetist | ☐ Physical Therapist | ☐ Emergency Medical Technician |
| ☐ Clinical Dietician | ☐ Nurse Midwife | ☐ Physician Assistant | ☐ Licensed Practical/Vocational Nurse |
| ☐ Clinical Pharmacist | ☐ Nurse Practitioner | ☐ Podiatrist | ☐ Other (*Specify*) |
| ☐ Clinical Psychologist | ☐ Occupational Therapist | ☐ Speech Pathologist | |
| ☐ Clinical Social Worker | ☐ Optometrist | ☐ Registered Nurse | |

# HOSPITAL DIRECTORY
# INFORMATION SHEET

LAST NAME: _____ FIRST NAME: _____

MIDDLE INITIAL: _____ RANK: _____

TYPE OF DEGREE (MD, DO MSW, ETC): _____

SCHOOL ATTENDED: _____

_____

YEAR OF GRADUATION/COMPLETION OF SCHOOLING: _____

SPECIALTY: _____

TRAINING: _____

DATES OF TRAINING/COMPLETION: _____

PLACE OF TRAINING: _____

INTERNSHIP (TYPE): _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

PLACE OF INTERNSHIP: _____

RESIDENCY (TYPE): _____

DATES OF RESIDENCY: FROM: _____ TO: _____

PLACE OF RESIDENCY: _____

BOARD CERTIFICATION: _____

## NATIONAL PRACTITIONER DATA BANK INFORMATION

| 1a. Practitioner Name Last (25) | 1b. First (15) | 1c. Middle (15) | 1d. Suffix (3) |
|---|---|---|---|
| 2a. Other Name Used Last (25) | 2b. First (15) | 2c. Middle (15) | 2d. Suffix (3) |
| 3. Organization Name (40)<br>BAYNE-JONES ARMY COMMUNITY HOSPITAL | | | |
| 4. Work Address (40)<br>1585 THRID STREET | | | |
| 5. City (28)<br>FORT POLK | 6. State (2)<br>LA | 7. ZIP Code (5 or 9)<br>71459-5110 | 8. If not U.S. Country (10) |
| 9. Home address (40) | | | |
| 10. City (28) | 11. State (2) | 12. ZIP Code (5 or 9) | 13. If not U.S. Country (10) |
| 14.a. License Number (16) If NO LICENSE state no license | 14b. State of Licensure (2) | 14c. Field of Licensure Code (3) | |
| 15. Date of Birth<br>MM-DD-YY | 16. Social Security Number (U.S) (9). | 17. Federal DEA Number (12) | |
| 18a. Professional School Attended (40) | | 18b. ear of Graduation (4) | |

### ADDITIONAL LICENSE NUMBERS

| a. License Number (16) | b. State of License (2) | c. Field of Licensure Code (3) |
|---|---|---|
| a. License Number (16) | b. State of License (2) | c. Field of Licensure Code (3) |
| a. License Number (16) | b. State of License (2) | c. Field of Licensure Code (3) |
| a. License Number (16) | b. State of License (2) | c. Field of Licensure Code (3) |

### ADDITIONAL FEDERAL DEA NUMBERS

| Federal DEA Number (12) | Federal DEA Number (12) |
|---|---|

I attest that the information provided above is accurate to the best of my knowledge. I also understand that failure to provide all information requested above could result in denial of clinical privileges at this medical facility.

_____

Signature/Date

# PROVIDER PERSONNEL PROFILE

---

NAME_____ SSN_____

BRANCH_____ RANK_____ DATE OF RANK_____

MILITARY SPECIALTY_____ DATE OF ARRIVAL ON STATION_____

PRESENT POSITION_____

DOB_____ PLACE OF BIRTH_____

OFFICE ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE(_____) - _____ - _____

HOME ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PHONE (_____) - _____ - _____

# VITAL STATISTICS

LAST NAME:_____ FIRST NAME/MI:_____

RANK:_____ SSN:_____

CORPS:_____ BRANCH/SVC:_____ CIVILIAN: GS:_____

CONTRACT: _____ CONSULTANT: _____

BIRTHDATE: _____ BIRTHPLACE:_____SEX:_____

MARITAL STATUS:_____ E-MAIL:_____ HOME PHONE:_____

HOME ADDRESS:_____ DUTY PHONE:_____

_____ PAGER #:_____

**********A CV MAY BE SUBSTITUTED FOR THE INFORMATION BELOW**********

MEDICAL SCHOOL:_____ DATE GRADUATED:_____

ECFMG:_____ EXPIRATION:_____

INTERNSHIP:_____ FROM:_____TO:_____

SPECIALTY:_____

RESIDENCY:_____ FROM:_____TO:_____

SPECIALTY:_____

RESIDENCY:_____ FROM:_____TO:_____

SPECIALTY:_____

FELLOWSHIP:_____ FROM:_____TO:_____

SPECIALTY:_____

FELLOWSHIP:_____ FROM:_____TO:_____

SPECIALTY:_____

BOARD CERTIFICATION:_____ EXPIRATION:_____
(NAME OF BOARD)

SUBSPECIALTY:_____ BOARD CERTIFICATION:_____EXPIRATION:_____
(DATE)

TEACHING POSITIONS PREVIOUSLY AND CURRENTLY HELD:_____

_____

HOSPITAL PRIVILEGES CURRENTLY HELD OR HELD WITHIN THE PAST FIVE YEARS:_____

_____

LIST ALL CURRENT AND PREVIOUS STATE LICENSES HELD:_____

_____