

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 asses 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.
Disclosure: 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 <i>(Last, first, middle)</i>	2. SOCIAL SECURITY NO. <i>(SSN)</i>	3. DOB	4. GRADE
5. CORPS	6. UNIT IDENTIFICATION	7. SPECIALTY BY TRAINING	

SECTION B - BASIC INFORMATION

8. LICENSURE/CERT.		9. DATE(S)	10. EXPIRATION DATE(S)
a. State Licensure <i>(If any)</i>			
b. DEA Number <i>(If any)</i>			
c. CPR Certificate			
d. ACLS Certificate			
e. BCLS Certificate			
11. BOARD ELIGIBLE FROM <i>(Date)</i>	12a. BOARD EXAM TAKEN <i>(Date)</i>	12b. CHECK <input type="checkbox"/> Total <input type="checkbox"/> Partial	14. MEMBERSHIP IN SPECIALTY SOCIETIES <i>(Specify)</i>
13. BOARD CERTIFIED? <i>(If yes, give name of Board(s)).</i> <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 seperate sheet of paper.)*

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

<i>The information contained herein is true to the best of my knowledge and belief.</i>	18a. SIGNATURE OF APPLICANT	18b. DATE
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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		8e. SIGNATURE				
8c. TITLE			8d. DATE						
9a. NAME OF UNIT COMMANDER			9b. GRADE		9e. SIGNATURE				
9c. TITLE			9d. DATE						

SECTION D - RECOMMENDATIONS OF SITE CREDENTIALS COMMITTEE

10. REMARKS	11. RECOMENDED STATUS <input type="checkbox"/> Conditional <input type="checkbox"/> Full	
	12. CLINICAL PRIVILEGES RECOMMENDED <input type="checkbox"/> As Requested <input type="checkbox"/> Other (<i>Specify in Item 12.</i>)	
	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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