

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, Pub. 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.

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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)

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

<input type="checkbox"/> Army	<input type="checkbox"/> Air Force	<input type="checkbox"/> Civilian GS	<input type="checkbox"/> Partnership External	<input type="checkbox"/> Non- Personal Services Contract
<input type="checkbox"/> Navy	<input type="checkbox"/> PHS	<input type="checkbox"/> Partnership Internal	<input type="checkbox"/> Personal Services Contract	

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

(1) Military		(2) Civilian	
<input type="checkbox"/> Volunteer	<input type="checkbox"/> National Guard	<input type="checkbox"/> Civil Service	<input type="checkbox"/> Consultant
<input type="checkbox"/> Armed Forces Health Professional Scholarship Program	<input type="checkbox"/> Reserve	<input type="checkbox"/> Contracted	
<input type="checkbox"/> Uniformed Services University of Health Sciences	<input type="checkbox"/> Other (<i>Specify</i>)	<input type="checkbox"/> Other (<i>Specify</i>)	

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	<input type="checkbox"/> Board Certified	<input type="checkbox"/> Residency Completed	<input type="checkbox"/> In Residency	<input type="checkbox"/> No Residency
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(3) Primary Specialty

<input type="checkbox"/> In Training <input type="checkbox"/> General Practice (GMO) <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Aviation Medicine <input type="checkbox"/> Dermatology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hematology-Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Nephrology	<input type="checkbox"/> Internal Medicine (cont.) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Rheumatology <input type="checkbox"/> Tropical Medicine <input type="checkbox"/> Allergy/Immunology <input type="checkbox"/> Cardiology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Neurology <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Otorhinolaryngology <input type="checkbox"/> Orthopedics	<input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Physical Medicine <input type="checkbox"/> Preventive Medicine <input type="checkbox"/> Psychiatry <input type="checkbox"/> Radiology <input type="checkbox"/> Surgery, General <input type="checkbox"/> Cardio-Thoracic <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Oncology <input type="checkbox"/> Pediatric	<input type="checkbox"/> Surgery, General (Cont.) <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Plastic <input type="checkbox"/> Underseas Medicine <input type="checkbox"/> Urology <input type="checkbox"/> Intensivist <input type="checkbox"/> Neonatologist <input type="checkbox"/> Other (<i>Specify</i>) <input type="checkbox"/> Oral Surgeon
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(4) Board Certification (s)	_____

(5) Other Practitioners:

<input type="checkbox"/> Audiologist	<input type="checkbox"/> Nurse Anesthetist	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Emergency Medical Technician
<input type="checkbox"/> Clinical Dietician	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Licensed Practical/Vocational Nurse
<input type="checkbox"/> Clinical Pharmacist	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Other (<i>Specify</i>)
<input type="checkbox"/> Clinical Psychologist	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Speech Pathologist	
<input type="checkbox"/> Clinical Social Worker	<input type="checkbox"/> Optometrist	<input type="checkbox"/> 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) BAYNE-JONES ARMY COMMUNITY HOSPITAL				
4. Work Address (40) 1585 THRID STREET				
5. City (28) FORT POLK		6. State (2) LA	7. ZIP Code (5 or 9) 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 MM-DD-YY	16. Social Security Number (U.S) (9).		17. Federal DEA Number (12)	
18a. Professional School Attended (40)				18b. Year 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: _____
