

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.

I have no disease or physical or mental impairment that would affect my ability to practice in my specialty and perform the privileges requested.

Signature of Provider

_____, to the best of my knowledge, has no disease/physical or mental impairment that would affect his/her ability to practice in his/her specialty and perform the privileges requested.

Signature-Clinic Chief/Careline Chief or DCCS

Typed/Stamped/Printed Name and Title

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
US GOVERNMENT		

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>(YYMM-YYMM)</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 *(YYYYMMDD)*