CREDENTIALS NEWCOMER'S ORIENTATION

WELCOME TO BROOKE ARMY MEDICAL CENTER

The Credentials office personnel wish to extend a sincere welcome to you and to assure you of our desire to expedite your inprocessing through this office.

A brief summary of the credentialing process is provided for your information. Following your completion of all required documents, your provider credentials file (PCF) is reviewed by the Service and Department Chief, and recommended for approval of clinical privileges. Your PCF will then be presented to the Medical Staff Executive Committee/Chairman for review and recommended approval. The Chairman of the Medical Staff Executive Committee will then forward recommendation for approval of your clinical privileges to the Commander for his final approval/disapproval. The credentials personnel complete all verifications prior to the Commander's approval/disapproval of privileges and medical staff appointment.

Folders are deferred due to outstanding deficiencies and the providers are not allowed to provide patient care until the Commander approves all privileges. The committee meets once a week (Wednesday, except for the third Wednesday). Once all the paperwork is completed, the packet will go before committee and will be presented for approval by the Commander. From Committee recommendation to Commander approval, the turn around time is approximately 2/5 days. There will be absolutely no temporary privileges granted, unless it is a patient care emergency, requested by the Service Chief and agreed upon by the Department Chief.

You will be notified in writing of the award of privileges and medical staff appointment. Upon receipt of notification, you need to sign, date and return the privileging memo to our office. A copy is provided for your records.

Below is a list of all the documents necessary for the credentialing process to be initiated. Please read, complete, sign and return all the enclosed documents. In all cases, please **INITIAL** in all blocks, do not √ or X.

a. Authorization for Release of Information (self-explanatory)
b. Request for Clinical Privileges memo (self-explanatory)
c. DA Form 5440A-R **Initial 2 a-v and Complete Section 6 a-l ONLY**
d. Complete the front of DA Form 4691-R, and section G on reverse (through signature and date) **ONE TIME ONLY**
e. Complete DA Form 5754-R. **Initial** in the Yes/No blocks. NOTE: item #4 is asking if you are licensed, and item #11 is authorizing us to verify same. Explain any licensure actions (voluntary or involuntary) in block #13.
f. Personnel Data for CHCS Entry (self-explanatory)
g. Complete the enclosed DA Form 5440--R by **initialing to the left** of the privileges you request.
h. DoD Physician Licensure Policy (self-explanatory)
i. Physician Statement of Acknowledgement and compliance with DoD Physician Licensure Guidance (self-explanatory)
j. Protocol form with attached protocols for privileged nurses (excluding CRNAs)
k. Scope of Practice for all CRNAs (self-explanatory)

Please provide the following documents (copy of) along with the above: **These documents require Prime Source Verification (PSV) to be done by this office and/or contracting agency, before presentation to the committee can take place**

a. Current CV/Resume (original)
b. Current State Licensure (copy of) **PSV**

c. Current Drug Enforcement Certification (DEA)(copy of) **PSV**
d. CPR Certification (**BCLS(mandatory)**, PALS, ACLS, ATLS encouraged
e. Current American Board Certification, if applicable (copy of) **PSV**
f. Medical School Diploma (copy of) **PSV**
g. Internship, Residency, Fellowship Diploma, if applicable (copy of) **PSV**

FOR CONTRACT, CONSULTANTS, CIVIL SERVICE, RESERVISTS, ETC. The following additional documents are required for your credentials file

1. Two recent letters of recommendation from peers. (original) (NTE one year old)
2. A letter from the hospital you are currently affiliated with along with a copy of the delineated privileges granted.

CME Requirements IAW AR 40-68/AR 40-48 are as follows
(providers are responsible for ensuring CME certificates are in your PCF) NOTE: Civilian providers are governed by the same CME requirements as active duty providers

1. Physicians: 150 Category 1 every three years (60 Cat I, 60 Cat II. Remaining 30 can be either CAT I/II)
2. Nurse Corps: 20 contact hours each year. In addition, you must meet the requirement of your state licensing board in order to maintain re-licensure
3. Army Medical Specialist Corps: 25 contact hours annually
4. Medical Service Corps: Minimum requirement annually for there specialty (the nationally recognized accrediting agency for each specialty sets it's own requirements
5. Physician Assistants: 100 credit hours of CME every two years, 40 hours must be Category 1. (40 hrs CAT I, 40 Hrs CAT II. Remaining 20 hrs can be in either CAT I/CATII)
6. **NOTE:** If the state license does not require CEUs, BAMC standard is 25 hours annually

PLEASE NOTE: You will be given a copy of the Medical Staff and Privileged Provider Bylaws when you inprocess. You must sign that you agree to read and abide by them during your practice/assignment at this command.

I certify that I have read, reviewed and completed all required documentation and have provided all required documents prior to being awarded privileges and medical staff appointment; and prior to providing patient care. I understand that it is my responsibility to ensure that all required documents are kept current in my PCF.

_____ _____
SIGNATURE **DATE**

I _____conducted an orientation briefing with this practitioner and explained the credentialing and privileging process, license and/or certification requirements, BLS and CME requirements and provider responsibilities.

_____
DATE

PRACTITIONER CREDENTIAL FILE

SECTION I

Privilege Memorandum
DA Form 5440A, Delineation of Privileges Record
DA Form 5440-XX-R, Delineation of Privileges (Specialty)
DA Form 5754, Malpractice and Privileges Questionnaire
Request for Privileges Memorandum
DA Form 5441-XX-R, Evaluation of Privileges (Specialty)
DA Form 4691-R, Initial Application for Privileges

Point of Contacts:
Sylvia Liserio, Credentials Coordinator
Dorothy Flores, Credentials Coordinator
Bonnie Rehm, Credentials Coordinator

Phone: (210) 916-2460
Phone: DSN: 429-2460
FAX: (210) 916-5102
FAX DSN: 429-5102

SECTION II

DA Form 5374-R, Performance Assessment

Brooke Army Medical Center
ATTN: MCHE-PSQ Credentials
3851 Roger Brooke Dr. Bldg 3600
Fort Sam Houston, Texas 78234-6200

SECTION III

National Practitioner Data Bank (NPDB)
Letters of Notification/Acknowledgement
Hearing Summary or Minutes
Investigations
Adverse Statements
Malpractice Claims

CHCS TRAINING
62405/3491
CPR Taining Office
6-0351/3571

SECTION IV

Continuing Medical Education (CME)
Curriculum Vitae/Resume (Lectures Given, Published Papers, Special Activities)

SECTION V

Copy of Orders
Credentials from Previous MTFs
Letters from Peers
Copy of Privileges at Civilian Hospitals

SECTION VI

Proof of Malpractice Insurance
CPR/BLS/ACLS/ATLS/PALS/NPR
State License/Renewal Certificates
Federal/State Narcotics License
National Commission for Certification of Physician Assistants (NCCPA)
Specialty Board
Fellowship
Residency
Internship
ECFMG
Medical/Ph.D./Masters DegreeBachelors/Registered Nurse Degree

DELINEATION OF PRIVILEGES RECORD

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

1. PERIOD FROM TO

2. Initial the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. Nurse Practitioners *(Pediatric)*
	C. Family Practice		K. Psychiatry		S. OB/GYN Nurse Practitioners
	D. Internal Medicine & Subspecialty		L. Psychology		T. Physician Assistants
	E. Neurology		M. Radiology/Nuclear Medicine		U. Emergency Medicine
	F. Obstetrics & Gynecology		N. Surgery		V. Other Specialty *(Specify)*
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC
Brooke Army Medical Center
Fort Sam Houston, Texas 78234-6200

B. APPOINTMENT TYPE
- ☐ Initial
- ☐ Active
- ☐ Affiliate
- ☐ Temporary
- ☐ None

C. PRIVILEGE CATEGORY
- ☐ Regular
- ☐ Temporary
- ☐ Supervised

D. DEPT/SVC *(Specify)*

E. DATE

G. CREDENTIALS COMMITTEE
DAVID D. ELLIS, COL, MC
Chairperson

H. DATE

F. SIGNATURE

I. SIGNATURE

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER
C. WILLIAM FOX, JR., BG, MC
Commanding

B. SIGNATURE

C. DATE

5. Remarks ADMITTING PRIVILEGES: ☐ YES ☐ NO CLINICAL PRIVILEGES: ☐ Granted as Requested ☐ Modified as Recommended

A review has been made of the provider's verified licensure, education and training, experience, capability to perform the requested privileges and demonstrated current competence.

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*

B. BOARD EXAMINATION TAKEN *(Date)* ☐ Total ☐ Partial

C. BOARD CERTIFIED ☐ No ☐ Yes *(Give Name of Board)*

D. RECERTIFICATION *(Board and Date)*

E. UTILIZED IN PRIMARY SPECIALTY

F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*

G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD

H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*

J. NAME OF APPLICANT OR PRACTITIONER

I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*

K. SIGNATURE

L. DATE

CRNA

DELINEATION OF PRIVILEGES RECORD

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

1. PERIOD FROM TO

2. Initial the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. Nurse Practitioners *(Pediatric)*
	C. Family Practice		K. Psychiatry		S. OB/GYN Nurse Practitioners
	D. Internal Medicine & Subspecialty		L. Psychology		T. Physician Assistants
	E. Neurology		M. Radiology/Nuclear Medicine		U. Emergency Medicine
	F. Obstetrics & Gynecology		N. Surgery		V. Other Specialty *(Specify)*
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC
Brooke Army Medical Center
Fort Sam Houston, Texas 78234-6200

B. APPOINTMENT TYPE
- ☐ Initial
- ☐ Active
- ☐ Affiliate
- ☐ Temporary
- ☐ None

C. PRIVILEGE CATEGORY
- ☐ Regular
- ☐ Temporary
- ☐ Supervised

D. DEPT/SVC *(Specify)*
JOSEPH J. HELMINIAK LTC, AN
C, ANESTHESIA NURSING SVC

E. DATE

G. CREDENTIALS COMMITTEE
DAVID D. ELLIS, COL, MC
Chairperson

H. DATE

F. SIGNATURE

I. SIGNATURE

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER
C. WILLIAM FOX, JR., BG, MC
COMMANDING

B. SIGNATURE

C. DATE

5. Remarks ADMITTING PRIVILEGES: ☐ YES ☒ NO CLINICAL PRIVILEGES: ☐ Granted as Requested ☐ Modified as Recommended

A review has been made of the provider's verified licensure, education and training, experience, capability to perform the requested privileges and demonstrated current competence.

CRNAs will collaborate with a physician (anesthesiologist if available) or oral surgeon, before induction of anesthesia in the operating room, for patients who are ASA Physical Status class III, IV, or V. This collaboration may be face to face or by telephone. The CRNA will document the results of this collaboration on the anesthetic record. The physician or oral surgeon may also document the results of this collaboration, but this is not required for an ASA Physical Status class III, IV, or V patient to receive anesthesia from a CRNA.

DAVID B. LONGENECKER, LTC, MC
C, ANES/OPERATIVE SVC

WENDALL C. BAUMAN, COL, MC
ACTING CHIEF, DEPT OF SURGERY

LARK FORD, COL, AN
DEPUTY COMMANDER
FOR NURSING

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*	B. BOARD EXAMINATION TAKEN *(Date)* ☐ Total ☐ Partial	C. BOARD CERTIFIED ☐ No ☐ Yes *(Give Name of Board)*
D. RECERTIFICATION *(Board and Date)*	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*
G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*	J. NAME OF APPLICANT OR PRACTITIONER
I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*		K. SIGNATURE / L. DATE

Scope of Practice for CRNAs
at BAMC
16 January 2001

1. Conduct preoperative evaluations on all patients, including ASA physical status classification determination on all patients. CRNAs will order appropriate tests and studies as part of perioperative evaluations of patients. CRNAs will collaborate with a physician (anesthesiologist if available) or oral surgeon if a specific patient's condition, as determined by the CRNA, requires collaboration as part of the preoperative evaluation.

2. Obtain informed consent on all patients for anesthesia services.

3. Determine that patients are appropriate candidates to undergo the planned anesthetic.

4. Select, prescribe or administer medications and treatment modalities related to the perianesthetic care of patients. No approved drug list required.

5. Conduct the assessment immediately before induction of anesthesia to assess the readiness of any patient to enter the surgical environment before committing to the anesthetic by its administration.

6. Select, obtain and administer anesthetics, adjunct drugs, accessory drugs, intravenous crystalloid and colloid infusions necessary to manage the patients in the perioperative period, to maintain the patient's homeostasis, and to correct responses to anesthesia and surgery.

7. Release or discharge patients from the postanesthesia care areas. CRNAs are not required to collaborate with a physician or oral surgeon before releasing any patients from the postanesthesia care areas or bypassing phase one recovery. CRNAs will consult with a physician (anesthesiologist if available) or oral surgeon if a specific patient's condition, as evaluated by the CRNA, requires collaboration or consultation.

8. CRNAs will collaborate with a physician (anesthesiologist if available) or oral surgeon, before induction of anesthesia in the operating room, for patients who are ASA Physical Status class III, IV, or V. This collaboration may be face to face or by telephone. The CRNA will document the results of this collaboration on the anesthetic record. The physician or oral surgeon may also document the results of this collaboration, but this is not required for an ASA Physical Status class III, IV or V patient to receive anesthesia care from a CRNA.

9. CRNAs will seek consultations or collaborations as needed for complicating or unexpected changes in a patient's medical condition during anesthesia care with a physician (anesthesiologist if available) or oral surgeon. This interaction will be documented in the anesthetic record by the CRNA. The physician or oral surgeon may

also document the results of this consultation or collaboration but this is not required for care to be provided by a CRNA.

10. In the unusual circumstance that a consensus concerning a clinical issue can not be obtained between a CRNA and an anesthesiologist or attending physician, the ultimate clinical authority and responsibility for anesthesia services provided for all classes patients will rest with the anesthesiologist or attending physician if an anesthesiologist is not available.

11. There is no requirement for CRNAs to be supervised for any particular age or group of patients for any particular type of procedure requiring anesthetic care. This is supported by AR 40-48 (2-1.d.2 and 3).

12. Required collaborations between a CRNA and an anesthesiologist (if available), or the decision by an anesthesiologist to insert him/herself into any case provides the opportunity for the anesthesiologist to become involved in the care of any particular patient.

13. CRNAs may seek collaboration, as determined by the CRNA, regardless of the patient's ASA classification. CRNAs remain accountable for every aspect of care and decision they make. Physicians are only held accountable for the specific aspects of care and decisions they make. Physicians are not accountable for the actions and decisions taken or made by a CRNA prior to the physician's engagement in a situation, or follow-on decisions made by a CRNA if the physician is not consulted.

14. CRNAs can supervise, within the limits of their own hospital privileges, student nurse anesthetist or other CRNAs. CRNAs can also supervise technicians, medics, nurses, medical students, interns and non-anesthesiology residents rotating on the anesthesia service involved in anesthesia care the CRNAs are responsible for.

15. In emergency, pain control and airway management situations outside of the operating room, the decision to collaborate or consult with an anesthesiologist (if available) will be left to the discretion of the CRNA. The primary physician responsible for the care of these patients will be consulted if present and notified if not present.

SIGNATURE_____ DATE:_____

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF

Date: _____

MEMORANDUM THRU Chief, Department of _____

FOR Chairperson, Medical Staff Executive Committee, Brooke Army Medical Center, Fort Sam Houston, TX 78234-6200

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment

1. I request an appointment to the medical staff of Brooke Army Medical Center and clinical privileges as specified on the enclosed DA Form 5440 Series, Delineation of Privileges form.

2. I certify that I possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and that I am clinically competent to perform in those areas.

3. I certify that I have no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.

4. If any change in my mental or physical state occurs during a privileging period, I will immediately, or as soon as physically able, notify a designated supervisor.

5. I **agree to furnish updated documents when they are received**, and to provide any documentation which is determined to be missing or lapsed from my credentials file upon request.

_____
Signature

_____
Type or Print Name and Rank

To the best of my knowledge, the above information is correct.

_____
Supervisor's printed name and signature

Printed on Recycled Paper

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF

MCHE-PSQ (40-68)

DATE_____

MEMORANDUM FOR Chairperson, Medical Staff Executive Committee, Brooke Army Medical Center, Fort Sam Houston, TX 78234-6200

SUBJECT: Request for Clinical Privileges

1. I request clinical privileges as specified on the enclosed DA Form 5440 Series.

2. I certify that I possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on forms, and that I am clinically competent to perform in those areas.

3. I certify that I have no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.

4. If any change in my mental or physical state occurs during a privileging period, I will immediately, or as soon as physically able, notify a designated supervisor.

5. I agree to furnish updated documents when received, and to provide any documentation which is determined to be missing or lapsed from my Credentials File upon request.

Enclosures

_____
(SIGNATURE)

_____
Typed/Printed Name & Rank

To the best of my knowledge, the above information is correct.

_____
SUPERVISOR'S TYPED NAME AND SIGNATURE

Printed on Recycled Paper

DEPARTMENT OF THE ARMY
GREAT PLAINS REGIONAL MEDICAL COMMAND
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF

MCHE-_____ (40-68) Date:_____

MEMORANDUM FOR Chairperson, Medical Staff Executive Committee, Brooke Army Medical Center, Fort Sam Houston TX 78234-6200

SUBJECT: Request for Renewal of Medical Staff Appointment and Clinical Privileges

1. I request renewal of my staff appointment and clinical privileges as delineated on the enclosed DA 5440 series.

2. I still possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and I am as clinically competent to perform in those areas as I was when I first applied for clinical privileges at this medical center.

3. I have developed no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.

4. If any change in my physical or mental state occurs during the privileging period, I will immediately, or as soon as physically able, notify a designated supervisor.

5. The following formation is furnished for review by the Medical Staff Executive Committee and will become a part of my permanent credentials file. Only those items that have not been regularly provided to the Credentials Office during the previous period are enclosed.

a. Proof of continuing medical education
b. Copy of current state licensure, showing expiration date (any/all current/lapsed licenses)
c. Copy of board certification (if certified/recertified since last request)
d. Copy of current BLS, ACLS, and/or ATLS certification
e. Copy of current, dated curriculum vitae (if changes since last submission)
f. DA Form 5754-R, Malpractice and Privileges Questionnaire

Encl

_____
Signature

_____
Typed/Printed Name/Rank

To the best of my knowledge the above information is correct.

_____
Supervisor's Signature

_____
Supervisor's Printed Name

Printed on Recycled Paper

DEPARTMENT OF THE ARMY
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF

MCHE-_____ (40-68) Date:_____

MEMORANDUM FOR Chairperson, Medical Staff Executive Committee, Brooke Army Medical Center, Fort Sam Houston TX 78234-6200

SUBJECT: Request for Renewal of Clinical Privileges

1. I request renewal of my clinical privileges as delineated on the enclosed DA 5440 series.

2. I still possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and I am as clinically competent to perform in those areas as I was when I first applied for clinical privileges at this medical center.

3. I have developed no mental or physical conditions, including alcohol or drug dependency, which would limit my clinical abilities.

4. If any change in my physical or mental state occurs during the privileging period, I will immediately, or as soon as physically able, notify a designated supervisor.

5. The following formation is furnished for review by the Medical Staff Executive Committee and will become a part of my permanent credentials file. Only those items that have not been regularly provided to the Credentials Office during the previous period are enclosed.

a. Proof of continuing medical education
b. Copy of current state licensure, showing expiration date (any/all current/lapsed licenses)
c. Copy of board certification (if certified/recertified since last request)
d. Copy of current BLS, ACLS, and/or ATLS certification
e. Copy of current, dated curriculum vitae (if changes since last submission)
f. DA Form 5754-R, Malpractice and Privileges Questionnaire

Encl

_____
Signature

_____
Typed/Printed Name/Rank

To the best of my knowledge the above information is correct.

_____
Supervisor's Signature

_____
Supervisor's Printed Name

Printed on Recycled Paper

MCHE-DN DATE: _____

MEMORANDUM THRU Chairperson, Medical Staff Executive Committee

FOR Inclusion in the Practitioners Credential File (PCF) of

SUBJECT: Protocol, Supervision, and Prescribing Privileges

1. Protocols:

a. IAW AR 40-68, mutually agreed upon protocols have been established for practice pertaining to the above named Health Care Provider (HCP).

b. The protocols are consistent with the scope of practice and are approved by supervisory personnel.

c. The protocols will be reviewed annually, updated as necessary and are readily retrievable within the Department of reviewing authorities.

2. Supervision:

a. The primary supervising physician for the above named is _____, MD. The supervising physician is required to perform monitoring activities of the treatment, referral and follow-up care that is provided by the above named HCP. The supervising physician will act IAW AR 40-68, Chapter 2, paragraphs 2-1 and 2-3.

b. The alternate supervising physician will be designated at the Department/Service level and will act IAW AR 40-68, Chapter 2, paragraph 2-3. The alternate physician is _____.

c. If the primary or alternate physician are not available for consultation, then the department/service will designate a specific physician for the HCP.

3. Prescribing Privileges:

a. A copy of the named HCP's prescribing privileges is enclosed.

b. Request for prescribing privileges for the above name HCP will be presented to the Pharmacy and Therapeutics Committee (P & T) for approval.

c. A copy of the P & T Committee minutes noting approval/disapproval will be forwarded to the Credentials Office for inclusion in the Health Care Provider's PCF.

SUBJECT: Protocol, Supervision, and Prescribing Privileges

(Health Care Provider's Signature)	Typed/Printed Name	(Date)
(Supervising Physician's Signature)	Typed/Printed Name	(Date)
(Chief, Department/Service Signature	Typed/Printed Name	(Date)
(Deputy Commander for Nursing)	Typed/Printed Name	(Date)

BROOKE ARMY MEDICAL CENTER

CCQAS AND CHCS DATA ENTRY FORM – PRIVILEGED HEALTH CARE PROVIDERS

Please indicate N/A if questions do not pertain to you.

NAME:_____ SSN: _____
(LAST,FIRST MI JR SR III

BRANCH: _____ RANK/GRADE: _____ DATE OF RANK: _____
(i.e., ARMY, AIR FORCE, CIVILIAN)

MILITARY SPECIALTY SERIES (AOC)/CIVILIAN GRADE SERIES: _____

FLYING STATUS: _____ YES _____ NO

DEPARTMENT/SERVICE ASSIGNED:_____
(I.E., Medicine/Surgery, etc.)

SPECIALTY: _____ SUPERVISOR: _____
(ORTHOPEDIC SURGEON, NURSE PRACTITIONER, PHYSICIAN ASSISTANT)

SIGNATURE CLASS:

NURSE
PROVIDER REQUIRING COUNTERSIGNATURE
HCP
COUNTERSIGNING HCP
CLERK WITH LIMITED ORDERING

OFFICE ADDRESS: _____
(i.e., BAMC/AMEDD C&S, etc.)

HOME ADDRESS: _____

WORK PHONE NUMBER: _____ HOME PHONE _____

FAX NUMBER _____ BEEPER _____

DATE OF BIRTH: _____ GENDER ____ PLACE OF BIRTH: _____

(OPTIONAL)

SPOUSE NAME: _____

OFFICE USE ONLY: MEPRS APPROVAL FOR WORKLOAD _____

DATA ENTERED BY CHCS _____