

REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
WILLIAM BEAUMONT ARMY MEDICAL CENTER
5005 N PIEDRAS ST
EL PASO, TX 79920-5001

MCHM-Credentials

MEMORANDUM FOR Credentials Officer

SUBJECT: Credentials/Privileging Documentation

1. Credentials Review:

A. Welcome to William Beaumont Army Medical Center

B. Pls review enclosed credentialing packet

(1) Pls insure all appropriate forms are correctly completed.

(2) Pls direct any questions/inquiries to phone no./ address provided below.

2. Credentials Documentation:

A. Credentials Forms: Application Packet

B. Required Documents

1. Current License,

2. Current CPR - Basic Life Support

3. Physician Statement/Compliance-Physician Licensure

4. Advance Practice Nurse Licensure Requirement

5. Current Civilian Delineation of Privileges

6. Current/Most Recent Civilian Appraisal/Evaluation

7. Current Letter of Reference

POC: ATTN: CQM/Charlie Alvara
WBAMC/MCHM-Credentials
5005 N. Piedras Street
El Paso, Texas 79920-5001
915-569-1386/DSN: 979-1386
FAX:569-1233

DELINEATION OF PRIVILEGES RECORD <small>For use of this form, see AR 40-68; the proponent agency is OTSG</small>			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 WILLIAM BEAUMONT ARMY MEDICAL CENTER 5005 North Piedras El Paso, Texas 79920-5001		B. Appointment Type <input type="checkbox"/> (1) Initial <input type="checkbox"/> (2) Active <input type="checkbox"/> (3) Affiliate <input type="checkbox"/> (4) Temporary <input type="checkbox"/> (5) None		C. CLINICAL PRIVILEGES <input type="checkbox"/> (1) Regular <input type="checkbox"/> (2) Supervised <input type="checkbox"/> (3) Temporary
D. DEPT./SVC (Specify)	E. DATE	G. CREDENTIALS COMMITTEE NEY M. GORE, III, COL, MC, Chairman		H. DATE
F. SIGNATURE		I. SIGNATURE		
4. Approval				
A. NAME OF HOSPITAL/DENTAC COMMANDER CARLA G. HAWLEY-BOWLAND, COL, MC, Commanding		B. SIGNATURE		C. DATE
5. Remarks In making this recommendation, the providers' physical/mental capabilities, education, training, experience and current competence have been taken into consideration by the Service/Department Chief respectively.				
** This provider (does / does not) have admitting privileges to this health center.				
6. Practitioner's Education/Training Update Complete each section below. NA=NonApplicable				
A. BOARD ELIGIBLE FROM (Date)	B. BOARD EXAMINATION TAKEN (Date) <input type="checkbox"/> Total <input type="checkbox"/> Partial	C. BOARD CERTIFIED <input type="checkbox"/> No <input type="checkbox"/> 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

PHYSICIAN STATEMENT OF ACKNOWLEDGEMENT AND COMPLIANCE
OF DOD GUIDANCE ON PHYSICIAN LICENSURE

(PLEASE INITIAL)

— I understand DoD Guidance on Physician Licensure
(ASD[HA] Memo, 14 May 99)

— I have a current, valid, fully unrestricted license from
the state of _____.

— I have a license from one of the following states and
attached is waiver request form. (Circle one)

Florida
Kansas
Massachusetts
Oregon
Pennsylvania

— I have other restricted licensure issues.
State license is in _____.

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

I have read the DoD Guidance on Physician Licensure
(ASD[HA] Memo, 14 May 99).

(Provider Printed Name)

(Provider Signature)

(Date)

APPLICATION FOR REQUEST FOR WAIVER OF ADMINISTRATIVE LICENSURE REQUIREMENTS

NAME _____ RANK _____
(Last) (First) (MI)

SSN _____

MTF _____ Department/Service _____

RMC _____

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 submitted 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)