

# INITIAL APPLICATION FOR CLINICAL PRIVILEGES

(For use of this form, see USMEPCOM Reg 40-1)

## DATA REQUIRED BY THE PRIVACY ACT OF 1974

**Authority:** Title 5, United States Code (USC), Section 301; Title 44, USC, Section 33101; 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 and experience.  
**Routine uses:** Determine and assess 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. DATE OF BIRTH <i>(Day, Mo., Yr.)</i>
4. FUNCTION: <input type="checkbox"/> CMO/ASST CMO <input type="checkbox"/> FEE-BASIS PRACTITIONER <input type="checkbox"/> CONSULTANT		5. MEPS

### SECTION B - PROFESSIONAL EDUCATION

6. NAME OF PROFESSIONAL SCHOOL	7. LOCATION	8. YEARS ATTENDED		9. TYPE DEGREE	10. DEGREE COMPLETED <i>(Day, Mo., Yr.)</i>
		FROM	TO		

### SECTION C - POSTGRADUATE TRAINING

11. NAME OF HOSPITAL OR INSTITUTION	12. LOCATION	13. TYPE PROGRAM <i>(Residency, etc.)</i>	14. DURATION	15. DATE COMPLETED <i>(Day, Mo., Yr.)</i>

### SECTION D - PREVIOUS ASSIGNMENTS

16. NAME OF ORGANIZATION	17. LOCATION	18. CLINICAL SERVICES DEPT. ASSIGNED	19. INCLUSIVE DATES <i>(Day, Mo., Yr)</i>	
			FROM	TO

### SECTION E - CERTIFICATION/PROFESSIONAL SOCIETY MEMBERSHIP

20. BOARD ELIGIBLE FROM <i>(Date)</i>	21a. BOARD EXAM TAKEN <i>(Date)</i>	21b. CHECK <input type="checkbox"/> TOTAL <input type="checkbox"/> PARTIAL	23. MEMBERSHIP IN SPECIALTY SOCIETIES <i>(Specify)</i>
22. BOARD CERTIFIED: <i>(If yes, give name of board(s))</i>  <input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION F - CREDENTIALS ACTION HISTORY *(If "yes" to any of the following, give full details on a separate sheet.)***

	YES	NO		YES	NO
26. Has your license to practice medicine in any jurisdiction every been limited, suspended, revoked, or voluntarily surrendered?			30. Has your narcotics registration ever been suspended or revoked?		
27. Have you ever been refused membership in a hospital medical staff?			31. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?		
28. Has your request for any specific clinical privileges ever been denied or granted with stated limitations?			32. Have you had or do you presently have a significant medical or mental health problem?		
29. Have your privileges at any institution ever been limited, restricted, or revoked?			33. Have you ever been a defendant or the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication, or any other resolved or open charges of inappropriate, unethical, unprofessional, or		

**SECTION G - CLINICAL PRIVILEGES APPLIED FOR**

34. PRIVILEGE(S) REQUESTED:

- To perform physical examinations within the scope of AR 40-501 and USMEPCOM Reg 40-1.
- To function as a physical profiling officer.
- To be a consultant in \_\_\_\_\_

35a. STATE LICENSURE		35b. DATE	35c. EXPIRATION DATE
No.	State		
<i>The information contained herein is true to the best of my knowledge and I request the privileges delineated in block 34.</i>		36a. SIGNATURE OF APPLICANT	36b. DATE

**SECTION H - REVIEW AND APPROVAL**

37. REVIEWED BY:

a. Chief Medical Officer <i>(Signature and Date)</i>	RECOMMEND: <input type="checkbox"/> Approval <input type="checkbox"/> Modification <input type="checkbox"/> Disapproval
b. Sector Surgeon <i>(Signature and Date)</i>	RECOMMEND: <input type="checkbox"/> Approval <input type="checkbox"/> Modification <input type="checkbox"/> Disapproval
c. USMEPCOM Deputy Command Surgeon <u>or</u> Medical Standards Officer <i>(Signature and Date)</i>	RECOMMEND: <input type="checkbox"/> Approval <input type="checkbox"/> Modification <input type="checkbox"/> Disapproval

38. APPOINTMENT STATUS:

- a.    Granted as requested                       Modified (See remarks)                       Disapproved (See remarks)

b. Remarks:

39. COMMAND SURGEON *(Signature and Date)*