PROVIDER CLINICAL ASSESSMENT AND QUALIFICATION

(For use of this form, see USMEPCOM Reg 40-2)

PRIVACY ACT STATEMENT

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.

Principal Purpose: To document the provider's professional qualifications as the basis for medical services appointment.

Routine Uses: To support the Provider Quality Management Program (PQMP). A copy of this form will be retained in the provider's PQMP file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your medical services appointment.

SECTION A - IDENTIFICATION

1. **Provider's Full Name:** *(Last, First, Middle)*	2. **National Provider Identifier (NPI):**	3. **Current Level:**

4. **MEPS:**	5. **Dates Covered By This Report:** *(MMM DD, YYYY)*
	From: To:

6. Function:

SECTION B - DEFINED PROVIDER LEVEL RECOMMENDATION

7. **Modification Recommendation:** ☐ a. DPC-1 ☐ b. DPC-2 ☐ c. DPC-3 ☐ d. DPC-4

☐ e. DP-1 ☐ f. DP-2 ☐ g. DPT ☐ h. Other, Identify Changes Accordingly:

8. Assessment Method: (check all that apply) ☐ a. Records Review ☐ b. Direct Observation ☐ c. Other, please specify:

SECTION C - CLINICAL PROVIDER ASSESSMENT

Use page 3, continuation sheet, as needed

9a. **CLINICAL JUDGEMENT: i.e. profiling proficiency and clinical knowledge** ☐ Excellent ☐ Successful ☐ Area of Concern

9b. **CLINICAL SKILLS: i.e. Interview and exam proficiency** ☐ Excellent ☐ Successful ☐ Area of Concern

9c. **REGULATORY COMPLIANCE:** ☐ Excellent ☐ Successful ☐ Area of Concern

9d. **MEDICAL DEPARTMENT DIRECTOR: i.e. Knowledge of DPC-4 administrative tasks**

10. Additional Comments/Remarks

SECTION D - FUNCTION MODIFICATION

11. Describe desired change if applicable:

SECTION E - REVIEW AND APPROVAL

12. Signature of Provider: *(Printed Name and Date)* Date

13. Evaluated by: *(Printed Name, Title and Date)* ☐ CMO ☐ ACMO ☐ Provider Review Panel Physician Date

14. Next Clinical Assessment Due on *(MMM DD YYYY)* ☐ FCA-2

15a. Command Surgeon/MECS or Authorized Designee, if applicable: *(Printed Name, Title, Signature, and Date)*

15b. ☐ Approve ☐ Disapprove

15c. Comments

16. Date of Next Review, if Applicable: (MMM DD, YYYY)

Signature:	Date:

Signature:	Date:

Signature:	Date:

Signature:	Date: