CONTRACT PROVIDER QUALITY MANAGEMENT FORM

(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 DPC Level:**

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

SECTION B - DEFINED PROVIDER CATEGORY (DPC) LEVEL RECOMMENDATION

6. **Modification Recommendation:**

☐ a. DPC-1 ☐ b. DPC-2 ☐ c. DPC-3 ☐ d. DPC-4 ☐ e. Other, Identify Changes Accordingly:

SECTION C - CONTRACT PROVIDER ASSESSMENT

Use page 3, continuation sheet, as needed

7. **Describe, with Specific Examples, the Provider's Performance/Abilities (include a separate MFR as needed):**

• Recommended DPC Level increases must include comments and verification that required proper training has been completed accordingly, (e.g. Chaperone Policy Training, DoDI6103.03, Mandated Training Hours, Blood Borne Pathogen, etc.).

• Justifying the recommended DPC Level changes in Section B due to performance issues, must be documented, in detail, in Section D.

SECTION D - PERFORMANCE REPORT

Use page 3, continuation sheet, as needed

8. **Performance Assessment Items the Provider is Currently NOT Fulfilling:** (Check all that apply)

☐ Basic Clinical Knowledge	☐ Cooperation With Personnel	☐ Leadership Capability
☐ Clinical Judgment	☐ Overall Professional Appearance	☐ Quality and Timeliness of Medical Documentation
☐ Clinical Performance	☐ Behavior Towards Applicants & Staff	☐ Participation/Attendance at Staff Meetings
☐ Communication Skills	☐ Fitness For Duty	☐ Unauthorized Extension of Work Day
☐ Rapport With Applicants	☐ Professional Conduct	☐ Other, please specify:
☐ Relationship With Colleagues	☐ Ethical Conduct	

9. **Provider's Full Name:**
(Last, First, Middle)

10. Describe any additional training and or action(s), in detail, that has taken place. Include dates and type of training/ action(s) and the Provider's response to it (include a separate MFR as needed):

11. Recommendation(s) for improvement or recommended training and or action(s) requested, include dates and type of training/action(s) accordingly (include a separate MFR as needed):

SECTION E - REVIEW AND APPROVAL

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

13a. Evaluated by: *(Printed Name, Title and Date)* ☐ CMO ☐ ACMO ☐ MEPS CDR ☐ HQ Physician/Authorized Representative

13b. **Check this box if it is recommended to NOT schedule the provider while the Contracting Officer Representative (COR) resolves any performance issue(s) noted:** ☐

14a. J-7/MEMD Provider Review Panel, Physician: *(Printed Name, Title, Signature and Date)*

14b. Recommendation:
☐ Approve ☐ Disapprove
(If "Disapprove", insert comments below or provide MFR for the record)

14c. Comments: *(Provide an MFR as needed)*

15a. J-7/MEMD, Director or Authorized Designee, if applicable: *(Printed Name, Title, Signature and Date)*

15b.
☐ Approved DPC-_____ ☐ Disapproved

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

SECTION F - CONTINUATION SHEET

Signature:	Date: