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 a contract 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. Provider Type**	**3. National Provider Identifier (NPI):**	**4. Current Level:**

5. **MEPS:**	6. **Dates Covered By This Report:** *(MMM DD, YYYY)*
	From: To:

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:

SECTION C - CONTRACT PROVIDER ASSESSMENT

Use page 3, continuation sheet, as needed

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

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

9. Recommendation(s)

SECTION D - PERFORMANCE REPORT

Use page 3, continuation sheet, as needed

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

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

SECTION E - REVIEW AND APPROVAL

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

12a. Evaluated by: *(Printed Name, Title and Date)* ☐ CMO ☐ ACMO ☐ MEPS CDR ☐ Provider Review Panel Physician

12b. **Check this box if it is recommended to NOT schedule the provider while the Contracting Officer Representative (COR) resolves any performance issue(s) noted:** ☐

13a. Provider Review Panel Physician: *(Printed Name, Title, Signature and Date)*

13b. Recommendation:
☐ Approve ☐ Disapprove
(If "Disapprove", insert comments below or provide MFR for the record)

13c. Comments: *(Provide an MFR as needed)*

14a. Command Surgeon/MECS or Authorized Designee, if applicable: *(Printed Name, Title, Signature, and date)*

14b.
☐ Approved DP_____ ☐ Disapproved

14c. Comments:

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

SECTION F - CONTINUATION SHEET

Signature:	Date: