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 - PROVIDER'S INFORMATION

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

4. Function: ☐ CMO ☐ Asst CMO (ACMO)	5. Assessment Period *(MMM DD, YYYY)* From: To:

6. List All Current and Active State Licenses Only:

State	State
State	State
State	State

SECTION B - CLINICAL ASSESSMENT AND COMMENTS

Use page 3, continuation sheet, as needed

7. Performs physical examinations IAW DoDI 6130.03 and USMEPCOM Reg 40-1:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

8. Functioning as a profiling physician:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

9. Clinical knowledge displayed:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

10. Clinical judgement:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

11. Clinical performance:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

12. Quality and timeliness of medical documentation:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

13. Communication skills:	☐ Excellent	☐ Successful	☐ Area of Concern	☐ Not Applicable (N/A)

Comments:

14. Full Name: *(Last, First, Middle)*

15. MEPS Medical Department Director: ☐ Excellent ☐ Successful ☐ Area of Concern ☐ Not Applicable (N/A)

16. Additional Comments/Remarks: ☐ Excellent ☐ Successful ☐ Area of Concern

SECTION C - DEFINED PROVIDER CATEGORY (DPC) LEVEL

17. Select DPC level if there is a change, based on this assessment:

☐ a. DPC-1 ☐ b. DPC-2 ☐ c. DPC-3 ☐ d. DPC-4 ☐ e. DPC-5

18. Assessment Method, *check off all that apply*:

☐ a. Records Review ☐ b. Re-qualification visit, date: ☐ c. Other, please specify:

19a. Provider's Signature, *if applicable*:

19b. DATE: (MMM DD, YYYY)

20a. Assessment Conducted By: *(Printed Name, Title, Signature and Date)*

20b. Overall Assessment:

☐ Successful ☐ Area of Concern Identified ☐ N/A

SECTION D - FUNCTION MODIFICATION

21. Select Change, if Applicable:

☐ a. CMO to FBP ☐ b. ACMO to FBP ☐ c. FBP to CMO ☐ d. FBP to ACMO ☐ e. CMO to ACMO ☐ f. ACMO to CMO

SECTION E - ASSESSMENT CERTIFICATION

22a. J-7/MEMD, Provider Review Panel, Physician: *(Printed Name, Title, Signature and Date)*

22b. Recommendation:

☐ Approve ☐ Disapprove

(If "Disapprove", submit an MFR accordingly)

23a. J-7/MEMD, Director or Authorized Designee: *(Printed Name, Title, Signature and Date)*

23b.

☐ Approve ☐ Disapprove

24. Next Clinical Assesment Due On: (MMM DD, YYYY)

SECTION F - MEPS COMMANDER ACKNOWLEDGEMENT

25. MEPS Commander, acknowledges receipt: *(Printed Name, Title, Signature and Date)*

Section G - Continuation Sheet

Signature:	Date: