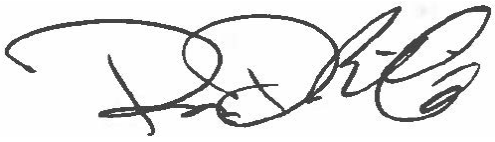
DEPARTMENT OF DEFENSE
HEADQUARTERS, UNITED STATES MILITARY ENTRANCE PROCESSING COMMAND
2834 GREEN BAY ROAD, NORTH CHICAGO, ILLINOIS 60064-3091

USMEPCOM Regulation
No. 40-2

Effective: July 8, 2025

Provider Quality Management Program

FOR THE COMMANDER:



OFFICIAL:

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Deputy Commander/Chief of Staff

DISTRIBUTION:
Unlimited. This Regulation is approved for public release.

Executive Summary. This regulation encompasses current policy and regulatory guidance for the USMEPCOM, Provider Quality Management Program (PQMP). This regulation prescribes USMEPCOM Forms 40-2-1 (Medical Provider Initial Application), 40-2-2 (Malpractice History and Status Questionnaire), 40-2-3 (Provider Clinical Assessment and Qualification), and 40-2-4 (Contract Provider Quality Management Form).

Applicability. This regulation applies to all elements of USMEPCOM.

Supplementation. Supplementation of this regulation is prohibited without prior approval of HQ USMEPCOM, ATTN: Office of the Command Surgeon, 2834 Green Bay Road, North Chicago, IL 60064-3094.

Suggested improvements. The proponent agency of this regulation is HQ USMEPCOM, ATTN: Office of the Command Surgeon. Users are invited to send comments and suggested improvements on Department of the Army (DA) Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQ USMEPCOM, ATTN: Office of the Command Surgeon, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Internal control process. This regulation contains internal control provisions and provides an internal control evaluation checklist, in Appendix E, for use in conducting internal controls.

*This regulation supersedes USMEPCOM Regulation 40-2, March 4, 2019. This major revision, effective July 8, 2025 has extensive changes throughout. Major changes have not been identified.

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Chapter 1
General

1-1. Purpose
The purpose of this regulation is to establish policies and procedural guidance for executing the USMEPCOM PQMP. This program provides technical and training guidance as well as quality oversight for USMEPCOM medical providers. The PQMP includes the following:

a. Initial Professional Credentials Review (IPCR) of medical provider credentials.

b. Training of medical providers to conduct accession medical evaluations of applicants for appointment, enlistment, or induction in the Military services (Accessions Medicine).

c. Maintenance of provider quality performance. The purpose of the PQMP is to promote and maintain standardization of applicant medical processing across the command such that the USMEPCOM medical providers consistently render medical qualification determinations IAW the Department of Defense Instruction (DoDI) 6130.03-v1, Medical Standards for Military Service: Appointment, Enlistment, or Induction.

1-2. Responsibilities
a. Command Surgeon will:

(1) Exercise primary staff responsibility and develop PQMP policies and procedural guidance.

(2) Review all PQMP proposed policy and procedural guidance and submit for USMEPCOM Commander approval and release for publication.

(3) Provide oversight and guidance on all PQMP related matters.

(4) Ensure quality and execution of the PQMP in strict adherence to this published policy command wide.

(5) Grant Defined Provider Category (DPC) and Defined Provider (DP) levels which define the specific accession medical services a provider is authorized to perform based on demonstrated skills or competency.

(6) Chair the PQMP Provider Review Panel (PRP).

b. Deputy Command Surgeon, Health Administration and Clinical Support will:

(1) Provide routine oversight and management of PQMP policies and procedural guidance.

(2) Supervise the PQMP and Fee Basis Provider (FBP) Coordinators to ensure proper execution of their assigned PQMP duties and responsibilities.

(3) Ensure policies set forth in this regulation are complied with across the Command.

(4) Coordinate with Acquisition and Contracting Special Staff Office (A&C) and associated contracting officer representatives (COR) and assistant contracting officer representatives (ACOR) on all medical contract issues requiring A&C subject matter expertise input.

(5) Coordinate and assist with planning and implementation of Medical Leadership Training Symposium.

c. The PQMP Director will:

(1) Provide direct oversight and management of PQMP policies, training programs, and procedural guidance.

(2) Supervise PQMP medical providers to ensure proper execution and timeliness of their assigned PQMP duties and responsibilities to include the PQMP inspection program.

(3) Ensure policies set forth in this regulation are complied with across the Command.

(4) Proactively establish measures of performance expectations for relevant medical disciplines.

(5) Oversee the PRP.

(6) Oversee and direct the Command peer review program to ensure a quality medical program and continued quality performance of the USMEPCOM medical provider pool.

(7) Serve as a member of the hiring panel for government providers as requested.

(8) Coordinates input on J-3 polices as they pertain to provider quality and procedural guidance, as indicated or required.

(9) Serve as the Command Surgeon designee for PQMP related actions, when delegated.

(10) Conduct applicant accessions medical processing at a local Military Entrance Processing Station (MEPS) location as directed by the Command Surgeon.

(11) Obtain and maintain DPC-5 provider designation.

d. PQMP medical providers will:

(1) Advise Command Surgeon and PQMP Director on all medical issues at the MEPS.

(2) Conduct the PQMP Inspection Program, according to guidance from the PQMP Director and the Command Surgeon.

(3) Conduct quality assessments as part of Chief Medical Officer (CMO) training and initial certification and recertification.

(4) Ensure MEPS medical best practices are brought to the attention of Medical Plans and Policy Directorate staff with appropriate, thorough, clinical and business-case analysis reports and recommendations for the appropriateness of Command-wide dissemination.

(5) Develops command medical policies and procedures and ensures their proper implementation.

(6) Oversee training for medical providers (government and contract) as required.

(7) Serve as a member of the hiring panel for government providers as requested.

(8) Conduct applicant accessions medical processing as directed by the PQMP Director.

(9) Coordinates input on J-3 polices as they pertain to provider quality and procedural guidance, as indicated or required.

(10) Obtain and maintain DPC-5 provider designation.

(11) Prepare and present PRP performance presentations. Ensure timely completion of PRP actions as applicable and provide closure notification and documentation to the Command Surgeon.

e. PQMP Government Coordinator (PQMP Coordinator) will:

(1) Prepare and manage government provider PQMP packages.

(2) Research credential policies, procedures, and information for applicability/non-applicability for PQMP use.

(3) Provide technical support for medical training.

(4) Update contract provider administrative system with credentials and qualification information.

(5) Provide PQMP support to the FBP contract COR and ACOR as needed.

(6) Collaborate with PQMP medical providers, Sector Medical Officers (SMO), and Regional Trainers (RT) on PQMP initial training scheduling for the Command Surgeon.

(7) Provide input and tracking of RT availability and training completion.

(8) Communicate with Command Surgeon, J-1, J-3 Medical Branch, SMO, and MEPS Commanders to ensure efficiency during the government provider hiring and initial training process. This includes, but is not limited to, review and vetting of candidate resumes, expected onboarding date tracking, onboarding communication with relevant MEPS personnel, initial training coordination to include identification and coordination with the RT.

(9) Manage PRP technical and logistical procedures for government providers.

f. PQMP FBP Coordinator (FBP Coordinator) will:

(1) Provide support to the PQMP to include but not limited to:

(a) Ensure vendor submissions meet contractual requirements.

(b) Prepare and manage FBP PQMP packages.

(c) Manage FBP performance issues to resolution through collaborative effort with all stakeholders involved to include the contract vendor, Command Surgeon, J-3 Medical Branch, SMO and MEPS personnel.

(2) Provide technical and clerical support for PRP meetings, including minutes to document actions taken.

(3) Provide FBP PQMP related data on a recurrent basis to the Command Surgeon and J-3 analysts in support of program evaluation.

(4) Update contract provider administrative system with credentials and qualification information.

g. The J-3 Director will ensure Headquarters (HQ) USMEPCOM J-3 providers will:

(1) Coordinate medical operations input on PQMP policies and procedural guidance, as required.

(2) Provide subject matter expertise and policy interpretation in support of the PQMP by responding to inquiries from internal and external sources.

(3) Serve as a member of the PRP when requested.

(4) Serve as the designee for PQMP related actions, when assigned.

(5) Provide support to MEPS Commanders in hiring actions of government providers by reviewing prospective CMO curricula vitae (CV) and by participating in candidate interviews, as requested.

(6) Should obtain and maintain DPC-5 provider designation.

(7) Ensure command wide compliance with the policies set forth in this regulation.

(8) Conduct applicant accessions medical processing as directed by J-3 Directorate leadership.

h. The Acquisitions and Contracting Director, or designee will:

(1) Serve as the USMEPCOM Commander’s principal contract representatives for FBP contract.

(2) Serve on the PRP as the contract advisor.

i. USMEPCOM Staff Judge Advocate (SJA) or designee will:

(1) Serve as the PRP legal advisor.

(2) Perform legal reviews for adverse PQMP actions for government providers and provide results to the Command Surgeon, as requested.

j. J-1 Human Resources Director, or designee will:

(1) Coordinate with the Command Surgeon's Office regarding all provider hiring and departing actions. This is necessary for a proper onboarding, training, and accounting of providers.

(2) Serve on the PRP as advisor on all personnel matters.

(3) Support market pay reviews every two years.

k. The Sector Commander will ensure SMO will:

(1) Serve as the Sector Commander's special staff officer and technical advisor on medical issues and PQMP.

(2) Obtain and maintain DPC-5 provider designation.

(3) Provide assistance and guidance to the MEPS Medical Department by promulgating current USMEPCOM policies and referring questions or issues requiring further policy interpretation to the J-3 Medical Branch or PQMP medical providers.

(4) Serve as a member of the hiring panel for government providers as requested.

(5) Assist with coordinating FBP training, and scheduling as needed with the FBP COR/ACOR. The SMO is not authorized to directly contact the FBP vendor.

(6) Assist with CMO Initial Training (CIT), nominate RT candidates from their respective Sector CMO providers, and assist in the coordination and completion of training, as required.

(7) Periodically conducts quality assessments of the MEPS CMO in coordination with PQMP activities and the Command Surgeon's Office.

(8) Assists the appropriate HQ, Sector, Battalion, and MEPS proponents with managing quality performance issues of government providers and FBP.

(9) Collaborate with Command Surgeon's Office and J-3 Medical Branch to maintain quality and standardization of the Medical Program.

(10) Assist MEPS Medical Departments with local peer review programs.

(11) Provide input for annual performance assessments for MEPS CMO to MEPS Commanders for use in civilian employee annual appraisals.

(12) Ensure Sector compliance with the policies set forth in this regulation.

(13) Conduct applicant accessions medical processing at a local MEPS location as directed.

(14) Supervise the Sector traveling Medical Officer (MO).

(15) Serve as the Director of the lab at the local MEPS in the absence of a government physician.

l. The Sector Commander will ensure all MEPS Commanders will:

(1) Ensure MEPS compliance with the policies set forth in this regulation

(2) Hire government providers through the local servicing civilian personnel activity IAW the requirements of this regulation.

(3) Have at least one provider on any hiring action for a government provider. This includes direct hires. Policy may require more for certain positions according to USMEPCOM Regulation (UMR) 690-13-1.

(4) Ensure PQMP Coordinator is notified of all projected government provider vacancies, hiring actions, candidate interview schedules, and projected start dates.

(5) Supervise the MEPS CMO and ensure non-clinical supervision of other government providers in the absence of a CMO. Ensure the CMO is performing required administrative and supervisory duties, per their position description (PD). When Service-specific policies prohibit the CMO position from supervising the Non-Commissioned Officer in Charge (NCOIC), the CMO will supervise the lead medical technician.

(6) Verify the FBP completes all required training and administrative requirements before they are permitted to provide accession medical services.

(7) In absence of a CMO, execute a MEPS PQMP Peer Review Program under the direction of a provider as described in the PQMP Peer Review Program Standard Operating Procedure (SOP).

(8) In absence of a CMO, ensure medical provider initial qualification, training, and performance documents are maintained locally by the MEPS Medical Departments as required in this regulation.

(9) In absence of a CMO, ensure medical providers are assigned a DPC level and provide accession medical services IAW their assigned DPC level.

(10) Coordinate with PQMP medical providers for completion of CMO quality assessments for use in CMO appraisals.

(11) Request assistance and coordinate with PQMP medical providers, J-3 Medical Branch, and SMO for provider performance issues including obtaining inputs for any CMO performance improvement plans.

m. The Sector Commander will ensure all MEPS CMO will:

(1) Ensure all local MEPS medical providers adhere to this regulation.

(2) Comply with initial medical training requirements as directed by the Command Surgeon's Office through the PQMP, to obtain DPC-4 designation.

(3) Supervise and train the Assistant Chief Medical Officer (ACMO), MO, other assigned government medical providers, and the MEPS Medical NCOIC or Supervisory Medical Technician (SUP

MT). When Service-specific policies prohibit the CMO position from supervising the Medical NCOIC, the CMO will provide supervision for the lead medical technician.

(4) Serve as the Director for the local MEPS Medical Department and execute the Medical Qualification Program and PQMP.

(5) Complete PQMP initial medical training requirements for all local providers.

(6) Ensure the FBP completes all required training and administrative requirements before they are permitted to provide accession medical services.

(7) Oversee the PQMP Peer Review Program for local MEPS medical providers, including development of the local process and procedures for implementing peer review locally to meet the requirements as outlined in the PQMP Peer Review Program SOP, reviewing the plan with the MEPS Commander.

(8) Document FBP performance issues for review by the Sector Medical Officer, Command Surgeon, PQMP Director, and FBP Coordinator for processing.

(9) Ensure other FBP contractual requirements are met in coordination with the COR/ACOR.

(10) Be familiar with the Command Surgeon's Sharing Policy, Experience and Resources (SPEAR) page, including where required forms are located.

n. The Sector Commander will ensure all MEPS ACMO/MO will:

(1) Participate in PQMP under the direction of the local CMO.

(2) As a DPC-4 provider, serve as subject matter expert for MEPS staff and other providers on MEPS medical processes and policy.

(3) Once qualified as DPC-4, in the absence of the CMO, the ACMO will serve as the Director for the local MEPS Medical Department and execute the Medical Qualification Program and PQMP.

(4) Once qualified as DPC-4, in the absence of both the CMO and the ACMO, the MO will serve as the Director for the local MEPS Medical Department and execute the Medical Qualification Program and PQMP.

o. The Sector Commander will ensure all MEPS Medical NCOIC and/or SUP MT will:

(1) Assist the MEPS Commander and government provider(s) in implementing PQMP requirements.

(2) Schedule medical provider training as required.

(3) Establish and maintain provider training folders (hard copy or digital).

1-3. Internal Control Checklists

This regulation establishes the use of an internal control evaluation checklist at Appendix E. Users of the checklists will use Department of the Army (DA) Form 11-2, Internal Control Evaluation Certification to document internal control evaluations.

Chapter 2
PQMP Structure

2-1. Elements of the PQMP
The PQMP consists of three elements:

a. Initial Professional Credentials Review (IPCR). The IPCR is conducted by the HQ providers of USMEPCOM and is the official review of a medical provider's professional credentials. Upon completion of the review, a provider is granted a DPC level 1, or DPC-1. Providers qualified as DPC-1 are eligible to be hired into government (CMO, ACMO, or MO) or contracted (FBP) medical provider positions and permitted to work at the MEPS or as part of the Prescreen Support Cell (PSCC).

b. Training. All new providers, both government and contracted, will receive standardized initial provider training. The goal of the PQMP initial provider training is to familiarize new providers with all applicable policy and enable them to conduct accession medical evaluations in a standardized manner and render accurate medical qualification determinations for applicants. The following Department of Defense (DoD) and USMEPCOM Medical Regulations are reviewed as part of the initial training:

(1) DoDI 6130-03-V1, Medical Standards for Military Service: Appointment, Enlistment, or Inductions with the USMPECOM Supplemental Medical Policy Guidance (SMPG)

(2) UMR 40-1, Medical Services Medical Qualification Program

(3) UMR 40-8, DoD Human Immunodeficiency Virus (HIV) Testing Program and Drug and Alcohol Testing (DAT) Program

(4) UMR 40-9, Bloodborne Pathogen Program

(5) Most up to date policy guidance related to Transgender Applicant Processing

(6) Most up to date policy guidance regarding Military Health System (MHS) GENESIS processing including standards of documentation and processes within the system. MHS GENESIS user training for providers is required to receive MHS GENESIS access and must be completed prior to a provider beginning PQMP initial provider training.

(7) Accession Medical Evaluation Standard Operating Procedures (AME SOP)

Note: Additional mandatory Medical Department training must be completed by the new provider IAW UMR 40-1.

c. Quality Maintenance. Government providers will ensure that their Medical Departments adhere to USMEPCOM Policy, seek policy clarification from the Command Surgeon's Office and J-3 Medical Branch as needed, participate in periodic provider quality assessments, conduct local peer reviews, and participate in chart reviews and USMEPCOM medical training programs. The CMO will conduct training and provide periodic assessments of their ACMO, MO, other assigned government medical provider, and assigned FBP. Quality maintenance activities under the PQMP provides recurring reviews, assessments, feedback, and sustainment training to ensure a quality medical program and continued quality performance of the USMEPCOM medical provider pool.

2-2. DPC Levels
DPC levels indicate a progression of increasing responsibility in the processing of applicants for Military Service according to the following:

a. DPC-1 is granted by the Command Surgeon, or their authorized designee, upon review of a provider's credentials and prior to beginning training. This level indicates that the new provider is in a training status at the MEPS under the direct supervision of a DPC-4, or higher, provider. The government or FBP candidate must be granted DPC-1 level before beginning work at a MEPS. A successful completion of a background check as well as obtaining a Common Access Card (CAC) are required before the contracted provider can begin working under the contract, to include PQMP training. This administrative requirement is not part of PQMP.

b. DPC-2 is granted by the Command Surgeon, or their authorized designee, upon review of the documented successful completion of the initial training. This level enables the provider to independently perform medical history interviews, medical examinations, and review supporting medical documentation. DPC-2 providers are not authorized to profile or render final medical qualification determinations for applicants. For government providers undergoing continuous training of less than 5 weeks, a separate DPC-2 evaluation is not required.
Note: FBP Nurse Practitioner (NP) providers are authorized to train to a maximum level of DPC-3. Whereas FBP Physician Assistant (PA) providers are authorized to be trained to a maximum level of DPC-2. Government MO (NP and PA) are authorized to train to DPC-4.

c. DPC-3 is granted by the Command Surgeon, or their authorized designee, upon review of the documented proficiency of the DPC-2 provider to perform the accession medical evaluation. This level enables the provider to independently render a medical qualification determination and to complete an applicant profile. DPC-3 level providers are not authorized to conduct training of other providers.

d. DPC-4 is granted by the Command Surgeon, or their authorized designee, upon review of documented proficiency by DPC-5 providers or DPC-4 RT. FPB DPC-4 must be nominated by DPC-4 G1, DPC-4 G2, DPC-5, or MEPS Commander. In the absence of a government DPC-4 provider, an FBP DPC-4 will clinically manage the MEPS Medical Department and may train other FBP to a maximum of DPC-3.

(1) DPC-4 G1 is designation applied to ACMO or MO providers. These providers clinically manage the MEPS Medical Department as delegated by the local CMO or during CMO absences. DPC-4 G1 are authorized to train both FBP and government providers to a maximum of DPC-3. If a MEPS has no DPC-4 G2, an exception to policy may be submitted to Command Surgeon to allow training of FBP to DPC-4.

(2) DPC-4 G2 is the designation applied to CMO. DPC-4 G2 providers clinically and administratively manage the MEPS Medical Department, as well as oversee and conduct training for government and contract providers to a maximum of DPC-4.

e. RT is a special category of DPC-4 provider and is granted by the Command Surgeon or their authorized designee upon nomination by a DPC-5 provider. RT must be DPC-4 G2 and complete the PQMP RT process. The RT designation is granted after CS review of documented proficiencies by a DPC-5.

f. DPC-5 is granted by the Command Surgeon or their authorized designee to HQ physicians (PQMP, J-3 Medical Branch, Sector), NP and PA. DPC-5 is considered a subject matter expert in the accession medical evaluation process. This level enables the DPC-5 designated provider to develop policy, provide technical guidance and advice regarding daily medical processing operation at the MEPS, conduct PQMP assessments, approve DPC level modifications, identify training needs, develop and provide focused training, and participate in PRP. A DPC-5 provider is authorized to conduct initial and periodic

qualification assessments of CMO as well as nominate government DPC-4 government providers as RT candidates.

g. The PSCC is composed of Prescreen Officers (PSO) and is managed under the operational control of the J-3 Directorate. The PSO is a provider (government or contract) who completes prescreens remotely for assigned MEPS command wide. PSO duties are categorized with DPC like non-PSCC providers. These categories are designated DP (as opposed to DPC) and are DP-1, DP-2, and DP-T. DP-1, DP-2 and DP-T providers are not trained to render a final medical qualification determination or complete the applicant profile, therefore these categories are not eligible to work in the MEPS Medical Department conducting accession medical evaluations or complete applicant profiles.

h. DP-1 is granted by the Command Surgeon or their authorized designee upon review of provider's credentials and prior to beginning training. This level indicates the new provider is in a training status under a DP-T or government trainer. The provider candidate must be granted DP-1 level before initiation of PQMP training. Completion of a successful background check and receipt of a CAC is required before the provider may begin work, including initiation of PQMP training. However, this administrative requirement is not part of PQMP.

i. DP-2 is granted by the Command Surgeon or their authorized designee upon review of the documented successful completion of initial training. This level allows the provider to independently perform medical history reviews and documentation of prescreen reviews. DP-2 providers are not authorized to profile or render final medical qualification determinations for applicants.

j. DP-T is granted to a DP-2 provider based on recommendation of a current DP-T or PSCC leadership. Only DP-T, DPC-4, or DPC-5 level providers are authorized to conduct initial and periodic training of PSO. For assistance with policy guidance and interpretation, DP-T level providers will confer via Service Now system with USMEPCOM HQ physicians.

Chapter 3
Initial Professional Credentials Review (IPCR) Program

3-1. IPCR for Government Providers

a. The MEPS Commander maintains hiring authority for their local CMO, ACMO, and MO positions through the local servicing civilian personnel activity. A DPC-5 physician will review a potential candidate's credentials and may participate in the applicant hiring panel, as applicable. Applicant resumes, to include generated referral lists, must be sent to the PQMP Coordinator for initial review prior to scheduling candidate interviews.

b. All provider candidates must meet the PQMP IPCR requirements in this chapter before being hired and be granted DPC-1 by the PRP before they begin work at a MEPS. Primary Source Verification (PSV) will be completed by the Command Surgeon's Office per Appendix B. Candidates with previous USMEPCOM PQMP training and/or experience may retain their current DPC level.

c. The PQMP Coordinator will assist government provider candidates with obtaining and submitting the required documentation. It is crucial for the MEPS to work closely with the PQMP Coordinator throughout the hiring process to ensure the IPCR is completed in a timely and efficient manner.

d. Required documentation for government provider hiring actions must be submitted electronically.

e. An FBP selected for a government provider position will have a UMF 40-2-3, Provider Clinical Assessment and Qualification modification completed for them by the Command Surgeon's Office. The PQMP Coordinator will review the provider's existing credentials file for completeness. New letters of recommendation do not need to be submitted.

f. A government provider selected for another government provider position will have a UMF 40-2-3, Provider Clinical Assessment and Qualification modification completed for them by the Command Surgeon's Office. The PQMP Coordinator will review the provider's existing credentials file for completeness. New letters of recommendation do not need to be submitted.

g. The MEPS Commander, or their designee, will notify the PQMP Coordinator of existing or anticipated government provider vacancies as well as the start dates for newly hired government providers.

3-2. Submission of Required Documentation for IPCR

Documentation supporting a provider's IPCR must be submitted to the PQMP Coordinator for PSV. A provider applying for a government position must submit documentation electronically directly to the PQMP Coordinator. FBP submit required credentials documents to the FBP contract vendor who is responsible for completing the PSV. The verified documents must then be submitted to the FBP Coordinator and A&C for review and approval.

The following documents are required for credentialing:

a. CV or resume. Information on the CV must be current, accurate and legible. The CV should contain: a list with the names of each organization or institution of previous professional employment in chronological order, the location of each organization or institution, the clinical area assigned, inclusive dates (month and year of each assignment), and a short summary of duties and responsibilities. Any gaps

in work history must be accounted for and explained. If there is no history of professional employment, then NONE must be annotated.

b. Current Active and Unencumbered State License(s) and Past License(s)

(1) As a term of employment, a provider must possess and maintain one license from a U.S. jurisdiction that meets the following requirements:

(a) Active - characterized by present activity, participation, practice, or use. The active license must be one allowing an independent level of practice and be granted by the recognized licensing agency of that State, the District of Columbia, the Commonwealths of Puerto Rico, Guam, or the US Virgin Islands.

(b) Current – not revoked, suspended, or lapsed. The provider must also submit an explanation for all current or past encumbered license(s). All other licenses, past or present, must be identified for review. Past license(s) must have been either in good standing at the time they lapsed or expired, or a written explanation must be provided.

(c) Valid and Unrestricted – not subject to state-imposed stipulations or restriction pertaining to the scope, location, or type or practice ordinarily granted to all other applicants for similar licensure in the granting jurisdiction.

(d) An NP must hold a license for advanced practice nursing either an Advanced Practice Nurse (APN) or Advanced Practice Registered Nurse license (APRN) in an approved educational area and national board certification completed as an NP. Additional requirements and nuances of NP licensure are as follows:

1. An NP must maintain their Registered Nurse (RN) license in states issuing a separate licensure for advanced practice nursing and require maintenance of the RN licensure for APN licensure.

2. For states who do not issue a separate licensure for advanced practice nursing, therefore the NP is practicing as an NP under their RN license, the stated scope of practice must specifically outline NP practice under the RN licensure issued by that state. The NP must meet the educational and board certification requirements outlined in the PQMP IPCR for NP in order to waive the requirement for an advanced practice nursing license.

3. A controlled substance license will not be supported for work conducted at USMEPCOM since prescribing of any type (legend or controlled drugs) is not authorized at USMEPCOM. For states where an APN specific license is only granted for controlled substance, the RN license will be used for USMEPCOM, following guidance in the above paragraph b(1)(d)2.

(e) PA must meet the minimum education and national board certification requirements for a PA as specified in paragraph 3-2.

(2) Collaborative Agreement not required for NP and PA.

(a) USMEPCOM has received a waiver authorization aligned with the waiver in DHA-PM 6025.13, v4 for NP and PA. USMEPCOM is not waiving the requirement for an active and unencumbered license, but is waiving licensure requirements for a collaborating physician for the PA. In order for the waiver to apply, the PA must meet the standard credentialing requirements which are aligned with DHA-PM 6025.13, v4 PA Credentialing Requirement which is a condition of the waiver.

(b) An NP is not required to have a collaborative agreement at USMEPCOM, however, the credential requirements listed in DHA-PM 6025.13, v4 must be adhered to, which are currently standard requirements in this regulation.

(3) The PQMP Coordinator will primary source verify documents for all government providers.

(4) The FBP contract vendor is responsible for providing a written PSV for an FBP on all past and present state licenses and submit copies of the verifications with supporting documentation, as needed, to the FBP Coordinator.

(5) If a PSV is not possible due to closure of the original issuing facility or other plausible reason, the license will be verified by the secondary or tertiary methods as listed in this guidance.

c. Professional School Diploma, Degree, and/or Completion Certificate

(1) All providers must supply copies of original diplomas or certificates indicating completion of training specific to their profession from Medical School, Nursing School, or PA programs.

(2) Both nursing degree diplomas and advanced practice nursing diplomas or certificates must be provided for NP. Submitted documents must undergo a PSV directly from the issuing organization or through the National Student Clearinghouse or Parchment.

(3) If a document is not in English, it must be translated by an official translator.

d. Educational Council for Foreign Medical Graduate (ECFMG)

A copy of the provider's ECFMG certification is required for providers who are foreign medical graduates, not including graduates from Canadian or Puerto Rican medical schools. Foreign language (excluding Latin) documents must be translated into English. ECFMG documents that are from 1985 or earlier must be translated into English, and the qualifying foreign medical degree must undergo a PSV with the issuing institution. Qualifying foreign medical degrees granted after 1986 do not need PSV as the ECFMG performs PSV for these documents.

e. Minimum Training and Clinical Experience Requirements

(1) The provider must submit their postgraduate training certificate(s), whether it is an Internship, Residency, or Fellowship. PSV with the issuing organization must be completed for all training. If unable to PSV directly with the hospital or program, training may be verified through the American Medical Association (AMA) or the American Osteopathic Information Association (AOiA) and not from a third party.

(2) A government physician must have at a minimum 12 months of post-graduate or clinical training (internship) verified by a certificate of completion.

(a) The training must have been completed with a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or Assembly of Osteopathic Graduate Medical Education (AOGME).

(b) All postgraduate training documentation must be submitted for PSV.

(3) Government physicians must have completed a residency or 24 months of direct, independent clinical experience post internship if a residency has not been completed. CV must show experience completing patient histories, conducting patient physical exams, and making diagnoses in the last five years.

(4) An MO must have at a minimum 24 months of direct, independent clinical experience functioning under the full scope of the NP or PA role in patient management including but not limited to completing patient histories, conducting patient physical exams, and making diagnoses in the last five years.

f. Verification of Certification: Provider certification will undergo PSV either directly with the certifying board or by using one of the following approved sources:

(1) Physician specialty board certificates, if applicable, may undergo PSV through the specific specialty board, American Board of Medical Specialties (ABMS), CertiFACTs Online, or AMA.

It is not necessary to delay the advancement of DPC level pending verification of board certification, as board certification for physicians is not a requirement for employment with USMEPCOM.

(2) National Board Certification for NP is a requirement for employment with USMEPCOM, NP must possess American Nurse's Credentialing Center (ANCC) or American Academy of Nurse Practitioners (AANP) certification. Certifications must undergo PSV. National Board Certification and educational program must be in one of the areas listed below. No exception will be granted as other NP categories of training are too specialized related to population age group, gender or scope of practice to apply to the military applicant demographics seen by USMEPCOM.

The Board Certification must be in the educational program area of advanced practice nursing in one of the following:

(a) Family NP (FNP)

(b) Adult NP (ANP)

(c) Adult-Gerontology (Primary Care or Acute Care) NP

(d) Acute Care NP

**Examples of Board Certifications that will not be accepted: Pediatric, Neonatal, Women's Health, Gerontology and Psychiatric Mental Health.

(3) National Certification for PA. As a requirement for employment with USMEPCOM, PAs must possess a National Commission on Certification of Physician Assistants (NCCPA) certification. Certifications must undergo PSV.

g. AMA Master File or AOA Master File: The PQMP Coordinator will obtain these reports for all government provider candidates. The FBP contract vendor will obtain these reports and submit to the FBP Coordinator for FBP candidates.

h. National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank: The PQMP Coordinator will obtain an NPDB result for government provider candidates. The FBP vendor will obtain an NPDB result and submit to the FBP Coordinator for FBP candidates. The NPDB request will

include all name variations including maiden name for a provider. The FBP vendor will submit an NPDB result to the FBP Coordinator every two years for FBPs.

i. The U.S. Department of Health and Human Services Office of Inspector General Exclusions Database must be checked upon initial credentialing and as part of regular credentials maintenance (every 2 years). Credentialing will be stopped for any provider found in the database.

j. Basic Life Support (BLS) for Providers: All DPC provider candidates will submit a current BLS for providers certificate from either the American Red Cross or the American Heart Association. Government providers will submit BLS certification certificates to the PQMP Coordinator. The FBP vendor will submit certificates to the FBP Coordinator for all contract providers. All providers must obtain recertification every two years. FBP certification will be at the vendor's expense, and completion documentation provided to the FBP Coordinator. BLS must be from the AHA or ARC provider course with Automated Electronic Defibrillator and include an in-person (not online) skills component or it will not be accepted.

k. Letters of Recommendation (LOR): Two current LOR must be returned to PQMP Coordinator to be included in the IPCR packet.

(1) The LOR Reference Form addresses clinical competency, quality of work, professional standing, and character and must contain contact information for the person providing the recommendation with the person's name, address and phone number. If the peer reference rates an area below satisfactory the Command Surgeon will review the explanation for the rating to determine suitability for the MEPS position. LOR will not be handwritten.

(2) All provider candidates must submit two LOR from another provider who may be a peer or supervisor. An exception to policy (ETP) may be approved by the Command Surgeon for LOR from another professional peer group if needed. For NP and PA candidates at least one (1) LOR must be from a physician (MD or DO) colleague.

3-3. Inability to Obtain Necessary Credentials PSV

Inability to obtain necessary credential verification may result in a modification of DPC level or failure to award DPC level. If the PQMP Coordinator or FBP contract vendor are unable to obtain verification due to destruction of the original documents, they will annotate the reason why the PSV could not be completed on a standard memorandum for the record and will attempt to verify the information from a secondary source.

3-4. Actions Following Initial Verification

While the government provider is continuously employed by USMEPCOM, or while an FBP is under the personal services contract, the following apply:

a. Licenses, registrations, and certifications must be re-verified through the PSV process as described above.

b. Specialty board certifications with expiration dates will be re-verified through either the AMA or AOA.

c. Credentials which do not expire or do not require reissue, such as a qualifying degree, do not need to be re-verified.

3-5. Initial Credentials Packet Approval

a. Upon PSV completion, government provider initial credential packets will be reviewed by the Command Surgeon or authorized designee. Upon PSV completion, FBP initial credential packets will be reviewed by PQMP medical provider followed by the Command Surgeon, or their authorized designee. The file review and input will include non-physician technical subject matter experts (e.g., PQMP Coordinator, FBP Coordinator, and FBP COR) without signature or approving authority.

b. When an initial credentials packet for a government or FBP candidate is disapproved, an informal PRP (iPRP) reviewer will document the reason(s) for disapproval. For government providers the PQMP Coordinator will notify J-1. The FBP COR is responsible for notifying the FBP vendor for the FBP candidates.

3-6. Provider Review Panel (PRP)

a. The reviewing providers are designated by the Command Surgeon and review the provider's quality assessments. The review may be informal or formal. For both the initial training and quality maintenance elements, the informal PRP (iPRP) or the formal PRP (fPRP) will make recommendations to the Command Surgeon for the approval of the advancement of a DPC level or for downgrade or removal of a DPC level.

b. The iPRP is chaired by the Command Surgeon who reviews and approves DPC level modifications. The Command Surgeon may delegate the final approval authority to an authorized designee. Other members of the iPRP include the J-3 Medical Branch, PQMP medical providers, and SMO.

c. Documentation will be reviewed and considered by the Command Surgeon and the assigned iPRP designee(s). Routing will be from the PQMP or FBP Coordinator, to the designated iPRP reviewer, then to the Command Surgeon, or their authorized designee, for the final approval.

d. The iPRP reviewer may request an fPRP if their initial review results in a recommendation for disapproval. The Command Surgeon or their authorized designee will determine if an fPRP will be convened.

e. Single provider iPRP review and authorization- The Command Surgeon may authorize review and approval by a single iPRP provider as indicated.

f. All training modifications recommended for approval by the training provider for advancement to the next DP or DPC level (DP-1 through DP-T or DPC-1 through DPC-5) are authorized for single iPRP provider review and approval.

g. The fPRP is chaired by the Command Surgeon and may include iPRP members as well as representatives from the USMEPCOM SJA Office, J-1 and the FBP COR. The fPRP meeting will convene to adjudicate documented concerns or issues and will provide formal recommendations to the Command Surgeon.

h. An adverse modification of a DPC level is an administrative action and is not necessarily reportable to a state licensing board. An adverse modification may result in a decrease of a DP or DPC level or removal of certain responsibilities associated with a DPC level. Recommendation for an adverse modification of a DPC level for a government provider will be documented in writing and will usually be reviewed by the fPRP. Recommendation for an adverse modification of a DPC level for a FBP will be documented in writing and will usually be reviewed by the iPRP. Government providers being reviewed for a potential

adverse modification of their DPC level will be notified in writing by the PQMP Coordinator of the documented concern(s) being reviewed. The government provider will be given an opportunity to present a written statement to the fPRP. SJA and J-1 will participate in any fPRP meeting which may result in an adverse modification.

i. If the fPRP determines a government provider has committed an egregious action, such as a criminal act, a report will be submitted to the appropriate legal and professional authorities by the Command Surgeon, or their authorized designee. If a provider is reported to have committed egregious acts for actions administrative in nature versus those related to provider quality, the Command Surgeon will work with SJA to determine the required reporting requirements. A memorandum for record will be included in the provider's credentials file.

j. If the fPRP determines an FBP has committed an egregious action, such as a criminal act, a report will be submitted by the Command Surgeon, or their authorized designee, through the FBP COR to the FBP contracting officer (KO) and the FBP contract vendor. The vendor, as the FBP employer, is responsible for administrative processing of allegations of improprieties by FBP.

3-7. Management of Provider Credentials Documents

Provider credentials are confidential, some contain Personal Identifiable Information (PII)/Protected Health Information (PHI), and therefore must be retained in a secure manner. Credentials may be stored electronically or in paper files. Those records maintained by the Command Surgeon's Office are in the custody of the PQMP and FBP Coordinators. Access to PII/PHI containing provider credentials will be granted only to specific medical staff at the MEPS, Sector specific medical staff, and PRP members on an as needed basis or as part of the initial credentials review or as part of a PRP review. Electronic files may also be created and maintained by A&C with controlled access to include PRP members and the FBP and PQMP Coordinators.

Chapter 4
CMO Training

New CMO training will be conducted IAW the standardized time frame detailed in this guidance, and will include the following:

a. In-processing: Prior to beginning the CIT, the new CMO must complete the Government Provider In-processing checklist. Other general USMEPCOM and Medical Department specific training and in-processing tasks should be completed if there is time prior to the CMO beginning CIT otherwise they may be completed upon return to the home MEPS. Note: Initial on-boarding may take at least two (2) weeks to complete.

b. CIT: CIT is a 15-business day training program for a new CMO intended to advance the new provider from DPC-1 to DPC-3. It may be reduced in length based on prior accession medicine training and experience. CIT usually occurs between weeks three (3) and five (5) after the CMO's initial start date but may begin later if requirements for travel have not been met. These requirements may include receipt of a Government Travel Charge Card and CAC, completion of Automated Time and Attendance Personnel System (ATAAPS), Defense Travel System training, and MHS GENESIS training, as well as creation of an MHS GENESIS user account. CIT is conducted by an RT. The CIT involves both observation and hands-on participation in medical processing under supervision of the RT. CIT will be conducted at the RT home MEPS over a minimum of one (1) week but will not exceed three (3) weeks. The duration of CIT will be determined by the RT based on assessment of the new CMO's proficiencies.

(1) Scheduling: In conjunction with the PQMP Coordinator, the respective SMO will identify one or more RT to oversee CIT. The SMO will assist the RT and CMO with coordination of training dates and notify the PQMP coordinator when scheduled. The CMO's home MEPS will assist with travel arrangements and completing the time sensitive in-processing items to ensure the new CMO is able to travel.

(2) Training: The CIT will be conducted IAW UMF 40-2-3, Provider Clinical Assessment and Qualification. For a new CMO with prior USMEPCOM PQMP training and/or USMEPCOM work experience, under the direction of the Command Surgeon the PQMP coordinator and PQMP medical providers will develop an individualized training program and timeline.

(3) DPC Level Advancement: At the conclusion of the CIT, the RT will provide a DPC-3 level recommendation by utilizing the UMF 40-2-3, Provider Clinical Assessment and Qualification. Instructions for completing this form are included at Appendix C. The form must be typed and should be electronically signed by the evaluated and evaluating providers and submitted to the PQMP Coordinator for processing. If evaluated provider disagrees and is unwilling to sign, recommend they submit a signed memo stating their points of disagreement.

(a) In some instances, the RT may note quality concerns with the new CMO and cannot recommend DPC-3 advancement within the standard timeline. If the RT believes that additional training will allow the new CMO to achieve DPC-3 proficiency, the RT will provide a written recommendation with a training plan on the UMF 40-2-3 to the respective SMO for review and recommendations. Supporting documentation, if applicable, should be submitted with the UMF 40-2-3. The SMO will submit the finalized UMF 40-2-3 and any supporting documentation to the PQMP Coordinator for PRP review. Requests for additional training will be reviewed by the iPRP provider(s), and the iPRP will make a written recommendation to the Command Surgeon, or their authorized designee, for final decision.

(b) If a new CMO is not able to achieve DPC-3 proficiency within the standard timeline, they may return to their home MEPS for an interim period before additional training begins. The respective SMO will develop a written plan of action for profiling coverage for the CMO's home MEPS during this interim period. The plan of action will be documented on a memorandum for record and sent to the Command Surgeon, or their authorized designee, for approval.

(c) Rarely, quality concerns are significant enough that additional training will not achieve DPC-3 proficiency, or completion of additional training did not result in adequate proficiency to recommend advancement to DPC-3. The RT's findings and recommendation will be annotated on the UMF 40-2-3 along with any supporting documentation and submitted to the respective SMO for review and recommendations. The SMO will submit the finalized UMF 40-2-3 and any supporting documentation to the PQMP Coordinator for PRP review. An fPRP will determine any further course(s) of action. The fPRP members will make recommendations to the Command Surgeon, or their authorized designee, for final disposition.

c. CMO Return to Home MEPS after CIT: Upon completion of CIT the new CMO will return to their home MEPS and perform the administrative functions of the CMO PD. The new CMO may not complete applicant profiles until DPC-3 approval is granted by the Command Surgeon, or their authorized designee. After completion of CIT, the new CMO is expected to advance to DPC-4, after successful completion of an Initial Quality Assessment (IQA) conducted by a DPC-5 provider.

Chapter 5
Quality Maintenance - Government Providers

5-1. Elements of Quality Maintenance
Government provider quality is maintained by the following:

a. Adherence to USMEPCOM policies regarding medical processing.

b. Seeking clarification on policy issues from J-3 Medical Branch, Command Surgeon's Office, SMO or via other means (ServiceNow system, email, phone, or Teams) as needed.

c. Periodic Quality Assessments conducted by DPC-5 providers.

d. Local peer reviews

e. Participation in the USMEPCOM continuing medical education program which includes HQ mandated training sessions, provider quarterly training, and the Medical Leadership Training Symposium (MLTS).

5-2. Adherence to USMEPCOM Current Policy
The CMO will ensure adherence to current USMEPCOM and DoD policy in the MEPS Medical Department to maintain the standardization and quality of daily applicant medical processing. Government providers will ensure that all pertinent written policies and regulations for applicant medical processing are available to all providers in the Medical Department. These copies may be maintained in either electronic or paper form.

5-3. Policy Clarification
A ServiceNow J-3 Medical Branch ticket will be submitted in the following situations:

a. Policy interpretation.

b. Assistance with rendering or documenting a medical qualification determination for an applicant. NOTE: This is required for any Processing Not Justified (PNJ) determination.

c. Disagreement among providers or with an outside agency (e.g. Service Medical Waiver Review Authority, Service Liaison, etc.)

d. Requests for an ETP. The Command Surgeon reserves the authority for all medical ETP approvals.

5-4. Quality Assessments
Quality assessments for the CMO under the PQMP include Initial Quality Assessments (IQA), Continuous Quality Assessments (CQA), and Focused Quality Assessments (FQA). Government and HQ provider assessments will be documented utilizing UMF 40-2-3. Instructions for completing this form are included at Appendix C.

a. IQA

(1) The IQA is a performance-based evaluation that is conducted by a PQMP medical provider after completion of the CIT. Additionally, The IQA may be conducted by a DPC-5 provider as designated by the Command Surgeon. The IQA is conducted to teach and validate the skills necessary for CMO

advancement to DPC-4. The IQA generally occurs between weeks six and ten after completion of CIT. The UMF 40-2-3 and IQA supporting documentation for the CMO will be submitted to the PQMP Coordinator for review by the iPRP. The Command Surgeon, or their authorized designee, will grant the approval of the IQA and UMF 40-2-3.

(2) If at the end of the IQA, the new CMO has not achieved the competencies to be advanced to DPC-4, the following actions may be taken:

(a) If quality concerns are noted, but the DPC-5 provider feels that additional training will enable the new CMO to achieve the competencies needed to advance to DPC-4, the DPC-5 provider will document the specific findings on the UMF 40-2-3 and will provide detailed recommendations for a training plan. The proposed training plan must include suspense and follow up dates. Additional training must have an FQA follow up visit within 90-days after the original IQA.

(b) If the new CMO is unable to achieve the competencies required for advancement to DPC-4 despite additional training, a recommendation for separation may be made IAW applicable civilian personnel regulations and procedures. Follow up IQA findings will be reviewed by the fPRP. fPRP members will make recommendations to the Command Surgeon, or their authorized designee, who will determine the final disposition.

(c) The DPC-5 provider will annotate the findings of the IQA on a UMF 40-2-3. The UMF 40-2-3 and any supporting documentation will be reviewed by the fPRP. The fPRP will make recommendations to the Command Surgeon, or their authorized designee, who will determine the final disposition.

(d) During the interim period after the IQA, but before remediation plan begins, the SMO will develop a clear plan to address applicant profiling and medical qualification determination oversight for the affected MEPS. This plan will be included as supporting documentation on the UMF 40-2-3 by the DPC-5 provider.

(3) An alternative method for the IQA may be used in extraordinary circumstances when a DPC-5 provider is unable to conduct an in-person follow up IQA visit. This alternative remote visit option must be approved by the Command Surgeon, or their authorized designee. Every effort will be made to conduct an in-person visit.

b. Continuous Quality Assessment (CQA)

(1) CQA is a credentialing requalification involving periodic performance-based evaluations primarily focused on the ability of the CMO to perform accessions medical evaluations and perform as the MEPS Medical Department Director. The CQA is conducted by a DPC-5 provider. The CQA will be conducted every one to three years following the IQA. New CMO will have a CQA conducted one year after their IQA unless the PQMP medical provider conducting the IQA provides strong support and clear rationale why a one-year CQA visit is not required. This recommendation will be documented on the UMF 40-2-3 used to document the results of the IQA.

(2) Requalification of all government providers and review of their credentials will occur every two years. The PQMP Coordinator will monitor expiration dates for credentials documents and request updated documents from government providers, as needed.

(3) Current BLS provider certification issued by the ARC or AHA is required as a condition for a providers' employment. Providers should not wait until the last minute to schedule their BLS recertification, as providers without a valid BLS card in their credentials file are not authorized to perform applicant medical processing. A UMF 40-2-2, Malpractice History and Status Questionnaire is required to be completed every two years. The PQMP Coordinator will obtain appropriate medical community updates. The original authorization which a provider signed for USMEPCOM to obtain documents will be used to obtain updates.

Note: It is the provider's responsibility to maintain up to date licensure, certification (as applicable), and BLS. Updated documents should be proactively sent to the PQMP Coordinator. Failure to maintain up to date licensure and BLS will result in the provider's inability to work in the MEPS until these are renewed. Administrative action may be recommended due to not meeting requirements of the position.

(4) DPC-5 level providers will medically process applicants on a periodic basis. CQA of SMO and J-3 providers will be conducted by PQMP medical providers as directed by the Command Surgeon. Quality Assessments for PQMP medical providers will be conducted by the PQMP Director.

(5) The following methods may be used during CQA:

(a) Periodic chart review (remote or during a MEPS site visit).

(b) Direct observation, simulation, or other methods as directed by the Command surgeon, or their authorized designee.

(c) Review of CMO administrative responsibilities by monitoring patterns of consult utilization, FBP utilization, diagnostic ordering trends, etc.

(6) Select data from CQA may be reviewed and analyzed annually by the Command Surgeon's Office. This data may be provided to MEPS Commanders to be included in the annual performance appraisal for the CMO. This data may include but is not limited to the following: Summary of CQA data, Biweekly CMO/ACMO Meeting, and MLTS attendance.

(7) Data trends from CQA may also be used for command-wide medical quality improvement.

(8) If a scheduled CQA cannot be completed within the documented timeframe, an alternative method of assessment may be utilized as directed by the Command Surgeon, or their authorized designee.

c. FQA

(1) An FQA may result from significant findings during both an IQA, CQA or may be initiated by the Command Surgeon, as deemed necessary. When a quality concern requires an FQA, a DPC-5 provider will document the issue and findings as well as recommend a remediation plan on the UMF 40-2-3. The completed UMF 40-2-3 will be reviewed by the Command Surgeon, or their authorized designee, for final disposition.

(2) FQA may be conducted for the following:

(a) An IQA or CQA identifies significant and/or recurrent errors or issues.

(b) When review of Special Inquiries (i.e. Inspector General, Congressional inquiries, etc.) identifies significant and/or recurrent errors/issues.

(c) When there are quality concerns related to processes of a specific MEPS Medical Department.

(d) When there are questions from accession partners concerning the quality of medical processing from a specific MEPS.

(e) By request of Sector leadership, J-3 Medical Branch, or by recommendation of the Command Surgeon, or their authorized designee.

(3) Authorization for an FQA is granted by the Command Surgeon, or their authorized designee. The details of a FQA will be documented on the UMF 40-2-3. Upon completion of the FQA, the findings and any recommendations will be documented on a UMF 40-2-3 and submitted to the PQMP Coordinator for review by the PRP. The PRP will provide recommendations to the Command Surgeon, or their authorized designee, for final disposition.

(4) Documentation of an FQA will include the following elements:

(a) Summary of observations.

(b) Detailed plan for remediation, if necessary, as well as a specific individualized timeline for completion of the follow up and close out.

(5) FQA may be conducted using the following methods, alone or in combination:

(a) Focused chart review of the provider.

(b) In person observation and assessment.

(c) Remote evaluation methods as directed by the Command Surgeon, or their authorized designee.

(d) Simulation.

(e) Other methods as approved in writing by the Command Surgeon, or their authorized designee.

(6) FQA may result in the following actions:

(a) If quality concerns have resolved or the provider's improved quality has been validated after completion of the FQA plan, the DPC-5 provider will complete a UMF 40-2-3.

(b) If quality concerns are validated and cannot be resolved during the FQA, and the DPC-5 provider believes that additional training will resolve the issue, the evaluator will request additional training as outlined above.

(c) If serious performance concerns (e.g. recommendation of down-grading or removal of certain DPC level responsibilities) are validated by the FQA, the DPC-5 provider will document their

findings on a UMF 40-2-3. The Command Surgeon, or their authorized designee, will convene an fPRP. The Command Surgeon may work with Sectors, J-3 Medical Branch, the MEPS Commander, and J-1 Human Resources to determine the appropriate course of action if the findings from the FQA require personnel action.

(7) All finalized FQA documentation will be kept in the CMO's credentials file and when applicable in the CMO's personnel file maintained at the MEPS.

5-5. Initial Training and Quality Assessments for ACMO and MO

Quality assessments for the ACMO and MO under the PQMP include IQA, CQA, and FQA. Government and HQ provider assessments will be documented utilizing UMF 40-2-3. Instructions for completing this form are included at Appendix C.

The MEPS CMO is the supervisor assigned for the local ACMO and/or MO and is responsible for conducting their IQA and CQA. In instances when the local MEPS CMO position is vacant, the ACMO or MO may travel to an RT for training. A DPC-5 provider may also complete the IQA, as determined by the Command Surgeon. In this instance, the local MEPS or Battalion Commander will coordinate with the SMO and PQMP Coordinator to develop an action plan to complete required training for the ACMO or MO.

a. ACMO and MO will complete Medical Department specific in-processing during the first weeks of employment. MEPS Medical Department Training and other required components should be completed before the ACMO or MO initial accessions training is initiated.

b. ACMO and MO will undergo initial PQMP training once they have obtained a CAC, completed MHS GENESIS training, and have an MHS GENESIS user account. The local CMO is responsible for conducting PQMP initial training IAW this guidance. The ACMO/MO PQMP Initial Training is a 15-business day training program that will follow the same content outline as the CIT. The goal of this initial training is advancement of the ACMO or MO from DPC-1 to DPC-3. At the conclusion of the initial training, the local CMO will document the training components and provide a DPC-3 recommendation by utilizing the UMF 40-2-3. Instructions for completing this form are included at Appendix C. The form must be submitted to the PQMP Coordinator along with any supporting documentation.

ACMO and MO will continue to receive additional training from the CMO to achieve DPC-4. This additional training will be conducted IAW the PQMP DPC-4 ACMO/MO training checklist. At the conclusion of this training, the CMO will provide a DPC-4 recommendation by utilizing the UMF 40-2-3. The DPC-4 should be achieved between six and ten weeks after award of DPC-3. If DPC-4 advancement cannot be achieved in this timeframe an ETP is required from the Command Surgeon. If the ACMO or MO is unable to reach DPC-4, the CMO must notify the PQMP Coordinator as soon as they are aware of the potential of failure of advancement so the Command Surgeon, or authorized designee, may develop an action plan.

c. The CMO is responsible for conducting a CQA for their assigned ACMO and/or MO. The CQA will be conducted every two years and will follow the same format as described in paragraph 5-4 of this regulation. The findings of the CQA will be documented using the UMF 40-2-3. Instructions for completing this form are included in Appendix C. The UMF 40-2-3 will be submitted to the PQMP Coordinator for review by the iPRP and approval by the Command Surgeon, or their authorized designee.

5-6. Peer Review Program

a. Local MEPS Peer Review Program is a mandatory ongoing quality review process implemented command wide. The PSCC is considered a geographically dispersed MEPS and will be subject to peer review requirements. The PSCC Officer in Charge (OIC) will serve as the PSCC CMO for purposes of peer review. The CMO will develop local procedures to conduct local peer review with assigned medical providers. The CMO will also oversee the local peer review program. Minimum requirements and recommended formats for local MEPS peer review programs are contained in the Peer Review Program SOP which may be found on SPEAR.

b. The CMO will conduct peer review for their assigned ACMO and MO.

c. PQMP medical providers, SMO, and/or J-3 providers, may assist with local peer review programs, as needed, for MEPS with a vacant CMO position.

d. FBPs will review each other's work on a regular basis.

e. All MEPS must adhere to the intent of the peer review program and will coordinate with the Command Surgeon's Office if there are issues or difficulties in completing recurring peer review.

f. At least one (1) hour of FBP Quarterly training, if authorized, will be reserved for local peer review.

5-7. Chart Review

a. Chart reviews are used to evaluate the quality of MEPS medical processing and clinical decision making and are an integral part of PQMP utilized in quality assessments and training. Occasionally, a PQMP medical provider, SMO, J-3 provider, or the Command Surgeon may conduct chart reviews for quality surveillance or as part of a planned quality assessment or focused quality review. For planned chart reviews that will be conducted during PQMP visits or remote review (IQA, CQA and FQA), random charts are reviewed using a standard Chart Review Worksheet.

b. Examples of chart review are:

(1) Chart reviews as part of the CIT.

(a) CIT: Chart review is a standard part of training oversight for the initial training process and will be conducted by the PQMP medical provider.

(b) IQA: Chart review is a standard part of the IQA. The PQMP medical provider will conduct chart review as part of a performance based, focused evaluation of the new provider to ensure accuracy, standardization and quality.

(2) CQA: Chart reviews are conducted as a standard part of the CQA. CQA may entail an action plan that includes a chart review in coordination with onsite or remote chart review as part of the evaluation.

(3) FQA: Chart review may be conducted as part of an FQA. If a chart review is required as a part of a FQA, the review may be completed onsite or remotely. If chart review is a component of a FQA, the parameters of the chart review must be detailed in the FQA action plan.

5-8. Participation in USMEPCOM Periodic Quality Maintenance Training (PQMT)

a. Medical Seminars: Attendance at the MLTS is mandatory for at least one government provider. An ETP for non-attendance may be granted solely by the Command Surgeon or their authorized designee and must be requested in writing by the MEPS Commander. If a MEPS has one government provider, that provider is required to attend MLTS or be exempted by ETP. If there are multiple government providers, at least one, preferably the CMO, must attend MLTS. For MEPS whose CMO was not able to attend MLTS, the CMO must review all available presentation materials with attestation of review supplied in the form of a signed memo. The memo will be submitted to the Command Surgeon's Office, and a copy maintained in the provider's training folder.

b. J-3 Medical Chalk Talks and/or other command-wide presentations: J-3 Medical Branch or the Command Surgeon's Office may periodically conduct command-wide presentations announced via the Command Message System. MEPS Commanders will ensure at least one government provider is available to participate, preferably the CMO, barring unforeseen medical mission requirements for applicant medical processing. Chalk talks are designed to provide regular clinical and medical processing updates to the field and promote quality and standardization of accessions medical evaluations. Attendance by at least one government provider is mandatory for each MEPS. Information presented during chalk talks will be used for quality maintenance training updates for the local MEPS provider pool and must be disseminated by the attendee to the other local government providers not in attendance.

5-9. Annual performance appraisal

a. The MEPS Commander is the supervisor of record for the CMO and is responsible for providing periodic constructive counseling and evaluation. PQMP assessments provide information on the clinical aspects of the CMO's job performance and serve as aids for the MEPS Commander to complete the annual performance appraisal.

b. The CMO is the supervisor of record for local ACMO and MO and will provide periodic progress reviews, constructive feedback and annual evaluations of their performance as part of the normal civilian performance plan feedback and appraisal process.

c. When an adverse action that may impact a civil service provider is being considered, the employee relations specialist (Civilian Personnel Office) must be consulted before any action is taken. This consultation is required to preserve employee's rights and to ensure that civilian employee guidelines are met. As a federal employee, the PQMP medical provider, SMO, CMO, ACMO, MO, PSO, and J-3 providers must be afforded a reasonable opportunity to demonstrate acceptable quality performance.

Chapter 6
Quality Maintenance - Fee Basis Providers (FBP)

6-1. Overview
This chapter provides policies and procedural guidance for managing FBP under PQMP to ensure quality and efficiency of their accession medical evaluations.

6-2. FBP

a. FBP are contracted by their employer, the FBP contract vendor. FBP must meet the PQMP IPCR requirements as described in Chapter 3, and have a signed personal services contract with the FBP contract vendor. Documentation requiring PSV will be processed by the FBP contract vendor as outlined in Appendix B. The MEPS will be notified in writing that a new FBP has been granted DPC-1 and assigned to their MEPS. FBP must be granted DPC-1 by the Command Surgeon, or their authorized designee, before they may begin work or training at their assigned (home) MEPS.

b. The FBP vendor is responsible for obtaining PQMP IPCR and approval of required documentation for FBP candidates. The FBP vendor will submit required documents to the FBP Coordinator for review and approval by the PRP.

6-3. FBP Initial Training (FBPIT)

a. An FBP cannot begin work remotely or onsite at the MEPS until the Command Surgeon, or their authorized designee, has granted a level of DPC-1 or higher. Additional contract and/or administrative requirements needed to begin work in the MEPS include:

(1) A signed personal service contract

(2) Background check clearance

(3) CAC

b. Prior to beginning DPC-2 training, the FBP will complete all USMEPCOM required JKO training (i.e. Cybersecurity, HIPAA, and MHS Genesis).

c. New FBP granted DPC-1 will undergo an initial training before advancement to DPC-2. This training will be conducted over no more than 40 hours, preferably within five (5) consecutive days, and within two (2) weeks of their official start date. The 40 hours does not begin until after the JKO training is complete. FBPIT will be documented on the templated UMF 40-2-4, Contract Provider Quality Management Form, and submitted to the FBP Coordinator for review and approval by the Command Surgeon's Office.

d. The CMO, or their authorized designee, is responsible for scheduling and conducting the FBPIT according to the DPC training checklists located on SPEAR. The trainer is expected to actively participate in FBPIT. FBP backfill is authorized if there is not an additional government provider onsite during FBPIT. If FBPIT has been delegated to an authorized designee by the CMO, both the trainer and CMO will sign the UMF 40-2-4. For MEPS that do not have a CMO, but have an assigned DPC-4 government provider, that provider will conduct FBPIT and complete initial training documentation on the UMF 40-2-4. A CMO signature is not required in these cases.

e. If the trainer determines that the new FBP cannot be advanced to DPC-2, the reasons for this determination must be documented using the UMF 40-2-4, Contract Provider Quality Management Form. Documentation must include specific examples of performance problems or quality concerns. The UMF 40-2-4 will be submitted to the PQMP Director for review and recommendations. The PQMP Director will submit the finalized UMF 40-2-4 to the FBP Coordinator for final disposition.

f. Advancement to DPC-3 is a requirement for MD, DO, and NP FBP. Training to DPC-3 must follow contract requirements and are detailed in the DPC checklist on SPEAR. Advancement to DPC-3 may not be recommended unless the eligible FBP has worked a minimum of 80 hours after advancement to DPC-2. This 80-hour requirement may be waived to a lower number of hours at the discretion of the MEPS CMO and with the approval of the Command Surgeon. Additionally, the trainer has 180 days to complete DPC-3 training with the DPC-2 provider. DPC-3 training is on the job training and is conducted as the FBP returns to work as a DPC-2 and opportunities arise to introduce them to and train them on the DPC-3 objectives detailed in UMF 40-2-4 DPC-3 training template on SPEAR.

g. DPC-4 advancement is not mandatory. An FBP may advance to DPC-4 upon the recommendation of the local CMO. HQ Physicians, ACMO, or MO may recommend advancement to DPC-4 in cases of CMO vacancies. The trainer will follow the FBP Training SOP and utilize the UMF 40-2-4 DPC-4 training template on SPEAR for training objectives and documentation of completion.

h. All UMF 40-2-4 training documentation must be submitted to the PQMP Director for review and approval by the Command Surgeon's Office.

i. FBP in support of The PSCC will be trained to DP-2. Providers must be trained by DP-T, DPC-4, or DPC-5 providers per established DP training checklists. This initial training should take up to 80 hours (in as many consecutive days as possible) to be recommended to DP-2. An FBP DP-2 may be supporting multiple MEPS.

6-4. FBP CQA

The FBP vendor is responsible for sending updated licensure, BLS and requalification documents to the FBP coordinator. In addition to maintenance of BLS and licensure, a UMF 40-2-2, Malpractice History and Status Questionnaire must be completed every two years. A new NPDB and AMA/AOA query must be submitted every two years as well. The original authorization signed by the provider for USMEPCOM to obtain qualification documents will be used to obtain updated documents for CQA. The FBP Coordinator will update the FBP system upon receipt of the requalification documents. If the documents are expired in the FBP system, the provider will be placed an inactive status and will not be able to work in the MEPS until updated documents are received and the FBP system is updated.

6-5. FBP Quarterly Training

FBP continuous training will be accomplished during the fiscal year (FY) using one of the following:

a. By direction of the Command Surgeon. This training will be documented using a Confirmed Training Order.

b. Group or individual training: The CMO will determine which option will be used for FBP Quarterly Training (FBPQT).

(1) Group Training (Option 1): With written approval of the MEPS Commander, up to four hours of the USMEPCOM Training Day may be used for medical training. The authorization for FBP to participate in USMEPCOM Training Day will be disseminated from HQ USMEPCOM via the Command

Message System. FBP may be requested, but not compelled to attend group training. If option 1 is used, a training plan must be developed, including topics and expected training duration, and written approval granted by the MEPS Commander. Group training time will not be used for "team building" activities. If an FBP cannot attend the group training session, a make-up will not be conducted. In this case training topics will be disseminated to the provider in a printed format and reviewed during regular work hours. Written acknowledgment of receipt and review of the training material will be placed in the provider's training folder. Training rosters will be used to document attendance at group FBPQT and maintained in the CMO's FBPQT File. The FBP Coordinator can provide further guidance for requesting FBP for group FBPQT.

(2) Individual Training (Option 2): This option allows MEPS to perform on the job training for one quarter each FY. For this option, a written training plan must be signed by the MEPS Commander and submitted to the Command Surgeon for approval. Up to four (4) hours of training may be approved for option 2 training. FBP backfill (DPC-3) is authorized for the trainer while conducting training. There are no make-up options if training is not completed as scheduled. Option 2 may take multiple days during the quarter to complete, however, the total number of requested FBP backfill should not exceed the number of FBP assigned to the MEPS. The MEPS must use this option in a cost-efficient manner, e.g., if the MEPS has two FBPs who need two hours of training, a request for a backfill FBP must be submitted for four hours; the trainer will spend the first two hours training one FBP, and the other two hours training the second FBP. A training roster will be used to document attendance of individual FBP Quarterly Training.

(3) Ad hoc Training (Option 3): The trainer may conduct ad hoc FBP training during the processing day. This is the most cost-effective option, as it does not require use of an additional FBP. The trainer will determine how to conduct this training. For example, FBP may be provided with a one-page summary on a specific topic for review during the processing day. Written acknowledgement of receipt and review of the training material will be added to the provider's training folder.

6-6. Establishment of FBP Folder and Training Procedures

a. MEPS are required to keep copies of PQMP documents for each FBP assigned to the MEPS. Documents may be maintained digitally or hard copy (i.e. FBP system.)

b. The provider training folder must contain the documents as described in Appendix D and stored in the MEPS Medical Department. If paper copy, these folders must be kept in a secure and locked file cabinet. If digital copy, these files must be maintained in a location where only authorized medical supervisory personnel, and the MEPS Commander have access. Supervisory medical personnel may designate other medical staff who have the authority to review information in the provider training folder. Providers may review their own folder. Folders will not be removed from the control of the MEPS medical staff. The folder must be updated with new training requirements, copies of current licenses, BLS cards, USMEPCOM forms. These documents will be provided to the MEPS Medical Department via encrypted email or the FBP system.

c. The Command Surgeon's Office will archive the USMEPCOM copy of the provider's training folder upon notification from the FBP vendor that a provider no longer works for them. The MEPS is then required to keep the provider's training folder for 2 years before destroying the provider's original folder.

6-7. FBP Performance Issues

a. If the MEPS Commander or a government provider determines an FBP is not meeting contractual performance standards, the observed issues will be documented on a UMF 40-2-4. The documentation

should include observed deficiencies, attempted corrections, and recommendations. The completed UMF 40-2-4 will be submitted to the SMO for initial review and recommendations. The finalized UMF 40-2-4 will be submitted by the SMO to the PQMP Director for submission to the Command Surgeon's Office for final disposition.

b. Emergency Situations are defined in the contract as issues with a FBP resulting in "reasonable suspicion that clear and present danger of physical harm exists" to an applicant, other FBP, government personnel, or authorized visitor. These situations will be addressed by the MEPS Commander in coordination with the local government providers as described below.

(1) In situations of clear and present danger, the MEPS Commander will follow the Emergency Management Assistance Plan to ensure the safety and well-being of all persons in the MEPS. If there is no imminent danger and the MEPS Commander, or local government providers, determine that the FBP should be removed from the MEPS, the MEPS Commander will contact the FBP COR or FBP ACOR immediately. **Note:** Per the FBP contract, the FBP COR will notify the vendor if the decision is made by USMEPCOM to remove the vendor's employee from the MEPS. MEPS staff will not contact the vendor directly in these situations.

(2) Once the emergency situation has been resolved, the MEPS Commander, in coordination with local government providers, will complete a UMF 40-2-4 detailing the incident and submit it and any supporting documentation to the FBP COR or FBP ACOR via encrypted email (osd.north-chicago.usmepcom.list.ac-contract-mgmt@army.mil). The subject line of the email must include the MEPS name, followed by "FBP-PR", and the last name of the provider. For example: Albany MEPS FBP-PR, Jones. The A&C FBP COR/ACOR will submit the performance report to the FBP Coordinator for review and approval by the Command Surgeon's Office within 24 hours of receipt. Once reviewed, A&C will submit the documentation to the FBP KO.

c. Non-Emergency Situations. For FBP performance issues observed while conducting routine applicant medical processing, the government provider(s), in coordination with the MEPS Commander, will notify the FBP verbally of performance issues (informal counseling). When applicable, the government provider(s) may provide additional training to the FBP to correct the noted performance issue(s), if the retraining does not require a backfill by a FBP (informal training). The government provider(s) or MEPS Commander should document verbal informal counseling and retraining on a memorandum for record which will be maintained locally. These memoranda may be used as supporting documentation if a formal performance report must be written. If the performance issues require retraining that will result in the need for a FBP backfill, the trainer will develop a plan for additional training which must be documented on a UMF 40-2-4 (formal training) and submitted to the respective SMO for initial review and recommendations. Once finalized the UMF 40-2-4 will be submitted to the FBP Coordinator for review and approval by the Command Surgeon's Office. Informal training for an FBP will be authorized without review and approval by the Command Surgeon's Office.

Performance issues requiring formal training must be documented using the UMF 40-2-4 and submitted to the respective SMO for review and recommendations. Once finalized, the SMO will submit the UMF 40-2-4 and any supporting documentation to the FBP Coordinator via encrypted email. The subject line of the email should include the MEPS name, followed by FBP-PR, followed by the last name of the provider. The FBP coordinator will forward the report to the PQMP Director for review and approval. Once approved, the FBP COR will submit the report to the FBP KO. If the performance issues are not corrected with additional training and warrant modification of the DPC level or a recommendation of termination, a UMF 40-2-4 must be completed documenting the reasons for the recommendation.

Appendix A
Letters and Forms for IPCR Documentation Requirements
Chapter 3 details the guidance for the IPCR.

A-1. Standard Request Letter and Information Release.

a. There are two required standardized letters, one requesting official participation in accession medical services with USMEPCOM and a second which is an "authorization for information release." These letters are not to be written on MEPS letterhead unless it is for a current Government employee. FBP letters may be submitted on FBP vendor letterhead. Providers are to print and sign their name.

b. Sample participation letter:

REQUEST FOR HQ USMEPCOM, ATTENTION Command Surgeon, 2834 GREEN BAY ROAD, NORTH CHICAGO, IL 60064-3091

I am requesting to provide accession medical evaluations at the _____ Military Entrance Processing Station (MEPS) as a _____ (Chief Medical Officer, Assistant Chief Medical Officer, Medical Officer, Fee Basis Provider).

I hereby authorize and consent to the release of information to or by USMEPCOM or its staff to or from other physicians or references, professional schools or training programs, medical associations, clinics or hospitals and their staff, or other employees on request regarding any information the sources may have concerning me, as long as the release of information is done in good faith and without malice. I hereby release all parties, including USMEPCOM and its members, for doing so."

_____ _____
Print Full Legal Name Date: MMDDYY

_____
Signature

A-2. Standard Release of Information Authorization Letter
(For FBP letters, the FBP vendor can be listed in the second paragraph of this letter along with USMEPCOM):

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize all who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated healthcare organization, its staff, and agents. These include individuals, institutions, and entities of organizations with which I am currently or have associated and all professional liability insurers with which I have had or currently have professional liability insurance.

I agree to release and hold harmless from any liability the United States Military Entrance Processing Command (USMEPCOM) and any and all persons who participate within the scope of their duties in good faith and without malice in the review of any action or recommendation relating to my application.

A-3. UMF 40-2-1, Medical Provider Initial Application. (Must be downloaded and opened in Adobe.) This form is sent directly to the provider by the PQMP Government Coordinator and is to be filled out in its entirety as follows:

SECTION A – IDENTIFICATION

Item 1a, Full name: List the provider's current full legal name.

Item 1b, (Maiden Names & Aliases, as applicable): List all previous names including maiden names and permutations of legal name used by the provider for but not limited to licensing, education, training, and work history records. Use Section E on the back side of the form to ensure all names are provided.

Item 2, National Provider Number (NPI): Self-explanatory.

Item 3, Date of Birth: Self-explanatory using the format MMM DD, YYYY.

Item 4, Function: Candidates for MEPS CMO positions will check the CMO option, candidates for MEPS ACMO positions will check the ACMO option, candidates for MEPS MO positions will check the MO option, and FBP contract candidates must only check the FBP option.

Item 5, MEPS: Name of local MEPS where the government candidate applied for a position or the local "home" MEPS where an FBP provider will be assigned.

SECTION B – PROFESSIONAL MEDICAL EDUCATION

Item 6a, Name of Professional School: List professional schools attended in chronological order starting with earliest first.

Item 6b, Type of Degree: List specific degree obtained.

Item 6c, Degree Completion Date: The month day, year the degree was completed in the format MMM DD, YYYY.

SECTION C – POSTGRADUATE TRAINING AND LICENSING

Item 7a, Name of Hospital or Institution: List name of hospital or institution where postgraduate training was performed. List multiple programs in chronological order with the earliest listed first.

Item 7b, Location: List location of the hospital or institution by city and state. If done outside the United States, give city and country.

Item 7c, Type of Program: List the type of post-graduate training, e.g., internship, residency, fellowship, practicum.

Item 7d, Date Completed: List the month day, year completed in the format MMM DD, YYYY.

Item 8a, State: List the state licensure states(s) for all active/current and past/inactive state licenses. List all active/current licenses first followed by the past/inactive licenses.

Item 8b, Status: List the state licensure status (es) for all state licenses using the words active or inactive (it is not necessary to state revoked or expired, just inactive)

Item 8c, Expiration Date: List the state licensure expiration date(s) for all active/current state licenses only.

Item 9a, Signature of Medical Provider Candidate: Self-explanatory.

Item 9b, Date: Annotate date (MMM DD, YYYY format) application was signed.

SECTION D: HEADQUARTERS REVIEW AND APPROVAL: For internal USMEPCOM use.

SECTION E: ADDITIONAL INFORMATION/COMMENTS: For use by the medical provider candidate to continue providing applicable application information.

Item 12a, Signature of Individual Providing Additional Information/Comments: Self-explanatory.

Item 12b, Date Signed: Annotate date (MMM DD, YYYY format) application was signed.

A-4. UMF 40-2-2, Malpractice History and Status Questionnaire. (Must be downloaded and opened in Adobe.) This form is sent directly to the provider by the PQMP Government Coordinator and is to be filled out in its entirety as follows:

Item 1, Name: List the provider's current full legal name.

Item 2, National Provider Number (NPI): Self-explanatory.

Item 3, Date of Birth: Self-explanatory using the format MMM DD, YYYY.

Item 4, Function: Candidates for MEPS CMO positions will check the CMO option, candidates for MEPS ACMO positions will check the ACMO option, and FBP contract candidates must only check the FBP option.

Item 5, MEPS Name: Name of local MEPS where the government candidate applied for a position or the local "home" MEPS where an FBP provider will be assigned.

Item 6a-m: Check box for appropriate answer to each question. All questions must be answered.
Note: If yes is answered to any of the questions, please explain in Item 7. If more room is needed, please use the back of the form or attach a typed explanation to the form which is signed and dated by the provider.

Item 7, Comments: Use this box to explain any "yes" answers.

Item 8a, Signature of Applicant: Self-explanatory.

Item 8b, Date Signed: Self-explanatory.

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Appendix B
Primary Source Verification (PSV)

B-1. PSV
The PQMP requirements include the PSV of a provider's medical license, education, and training as documented in Chapter 3. A primary source is the original source of a specific credential that can verify the accuracy of a qualification reported by a provider or licensed individual.

B-2. PSV Requirements
Documents required by the PQMP can be verified by one of the following methods, listed in order of preference. Each step must be attempted in order; if documents are incapable of being primary source verified, each attempt must be described and recorded in a memorandum and submitted along with the provider's documents in the request for certification.

a. Written confirmation from the issuing authority in the form of a letter or an email. For email correspondence, the institution and responder must be clearly identified. In the case of qualifying degrees, certified copies of the final college transcripts are acceptable if the type of degree and the date the degree was conferred are included on the transcript and the document came directly from the issuing authority or their authorized designee.

b. Verbal telephone confirmation from the issuing authority. This confirmation must be annotated on the copy of the document being verified or in a separate memorandum and include the following:

(1) the date of the conversation,

(2) agency contacted for the verification,

(3) agency phone number,

(4) name and title of the individual at the agency who verified the information,

(5) the specific information provided,

(6) and the signature and signature block of the person who performed the verification. The signature block of the person requesting verification will include full name, title, and organizational address and phone number.

c. By obtaining an AMA Master file or AOiA Master file.

d. Internet or website Verifications. The use of a professional organization's website is permitted for PSV of credentials by HQ and vendor's credentials verification coordinator if:

(1) The information is obtained directly from the professional organization's website.

(2) Use of the website of another recognized professional organization is permitted if it is used as the platform to reach the intended site. The HQ and when applicable the vendor's credential coordinator, must confirm the website used is the professional organization's official website, e.g. National Clearing House.

(3) The information on the website contains all the information required for the PSV process of the specific credential, to include sufficient information to properly identify the applicant. For example, name alone might not be sufficient to distinguish the applicant.

(4) HQ, and when applicable the vendor credential coordinator, must know the currency of information on the website. Information on the website that is supplemental to the information undergoing PSV, such as a state licensing board's website including information on the individual's specialty, is not to be used as PSV data, although it may be useful in evaluating the overall package of information gathered by an individual on the provider.

(5) HQ and/or the vendor must verify that the source website, when not located at, and under the direct control of the professional organization, receives its information directly from the professional organization's database through encrypted transmission and it is protected from alteration by unauthorized individuals.

(6) HQ may contact the professional organization by telephone or written correspondence if there is cause or if there is a discrepancy between what the applicant provided and the information on the website.

(7) The signature block of the person completing verification, along with the date, must be placed on the website printout or other record of information and will include the individual's full name, title, and organizational address and phone number.

e. Least preferred, Touchtone Telephone PSV. Touchtone telephone PSV (in which the caller does not speak with an actual person; instead, the caller electronically accesses a database) is acceptable only if the other methods listed above are not possible and must be annotated as such.

B-3. PSV Chain of Transmission

The chain of transmission of the document or information is what distinguishes PSV from secondary source verification. The document or information must come directly from the issuing authority to be considered a PSV. Documents delivered and/or provided directly from the provider still require PSV.

B-4. Document Copies

Copies of diplomas, certificates, licenses, etc. are NOT considered PSV, even if one personally makes the copy from the original document.

B-5. PSV Attempts

A reasonable attempt to PSV a document is defined as making a second attempt to solicit the necessary information. If still unsuccessful, annotate the effort, file documentation in the credential package and identify the problem in writing.

B-6. Equivalent Sources

The following are considered designated equivalent PSV:

a. The AMA Physician Master file may be used for PSV of US medical school graduation and US residency program completion.

b. The AOA Master file may be used as PSV for US medical school and US residency program completions for osteopathic physicians.

c. The ECFMG for verification of physician's graduation from a foreign medical school.

Note: If unable to obtain verification due to destruction of original documents by fire or natural disaster, annotate the reason the PSV could not be completed and attempt to verify the information via a secondary source.

B-7. Credential Document Authentication
Annotating authentication true and valid copy of a credentialing document is not an acceptable method of PSV.

B-8. Actions Following Initial Verification
If the provider is continually employed by the DoD or as a FBP under a personal services contract, the following will apply:

a. Licenses, registrations, and certifications must be re-verified as described above.

b. Specialty board certifications with expiration dates must be primary source verified at time of reissue.

c. Credentials which do not expire or require reissue, such as a qualifying degree, do not need to be reverified if the provider is continually employed by the DoD or the FBP is employed under a personal services contract.

B-9. Inability to Obtain Necessary Credentials PSV
Inability to obtain necessary credential verification will be considered when recommending the award of a DPC level and may result in a modification of DPC level or failure to award DPC level.

Note: If unable to obtain verification due to destruction of original documents by fire or natural disaster, annotate the reason the PSV could not be completed and attempt to verify the information from a secondary source.

Appendix C
Provider Clinical Assessment and Qualification

UMF 40-2-3, Provider Clinical Assessment and Qualification. This form is to be filled out in its entirety as follows:

SECTION A – PROVIDER'S IDENTIFICATION

Item 1, Full Name: List the provider's current full legal name.

Item 2, Type: List the provider type, MD/DO/NP/PA

Item 3, National Provider Number (NPI): Self-explanatory.

Item 4, Current DPC Level: List the provider's current Defined Provider Category Level (e.g. DPC-1, DPC-2, DPC-3, DPC-4)

Item 5, MEPS: List the provider's assigned MEPS

Item 6, Dates Covered by This Report: Time frame for the assessment provided in a From: MMM DD, YYYY To: MMM DD, YYYY format.

Item 7, Function: Select the provider's function from the dropdown (MO, CMO, ACMO, FBP, Other)

SECTION B – DEFINED PROVIDER LEVEL RECOMMENDATION

Item 8, Modification Recommendation: Select which level the provider is being recommended for.

Item 9, Assessment Method: How was the assessment conducted.

SECTION C – CLINICAL PROVIDER ASSESSMENT

Item 10, Describe, with Specific Examples, the Provider's Performance/Abilities (include a separate MFR as needed): Each medical service assessment will be evaluated, and comments provided.

Item 11, Provider's Full Name: Self-Explanatory

Item 12, Additional Comments/Remarks: Annotate comments for use in the evaluation and review of the provider. Annotate comments as to why a DPC level change in Item 8 is being requested along with any justification or remarks for the Command Surgeon and PRP staff to review.

SECTION D – FUNCTION MODIFICATION

Item 13: Annotate what category they are moving from and what category is being requested. (i.e. from CMO to FBP, ACMO to CMO)

SECTION E – REVIEW AND APPROVAL

Item 14, Provider's Signature and date: Self-explanatory.

Item 15, Assessment Conducted by: Print the name of the person doing the assessment, the person's title, have the person sign and provide the date the person signed.

Item 16, Next Clinical Assessment Due on: Date the next clinical assessment is due.

FQA-2: Check this box if this is a follow up to another FQA.

Item 17a-17c. For internal Command Surgeon-use only.

Item 18: Date of Next Review, if Applicable: Self-explanatory.

SECTION G- CONTINUATION SHEET
Additional documentation is placed here. The Item number that corresponds to the continuation documentation should be placed in the section prior to the documentation.

Appendix D
Provider's Training Folder Requirements

D-1. Folders should include the following documents:

a. Mandatory PQMP Documentation

(1) UMF 40-2-1, Medical Provider Initial Application.

(2) UMF 40-2-3, Provider Clinical Assessment and Qualification (when applicable).

(3) UMF 40-2-4, Contract Provider Quality Management Form (if applicable).

Note: If a form is part of PRP requalification process, you may place a copy of the form in the folder until receipt of the signed form from the PRP. Only current PQMP documentation shall be maintained in the provider's training folder.

b. A copy of the FBP's current BLS card and current license.

c. Medical Training Requirements Documentation (IAW Chapter 19, UMR 40-1).

d. Initial Training Document and Annual Training Document IAW Chapter 19 UMR 40-1
Includes Standard Precautions, Chaperone Policy and Cerumen Removal

e. Command Training Requirements for IT System Access and MHS GENESIS Access

(1) Cyber Awareness Challenge DoD Version

(2) PII and HIPAA

(3) DD Form 2875, System Authorization Access Request.

f. Miscellaneous Documentation, e.g.:

(1) Local Medical Department training documentation.

(2) USMEPCOM Training Day Documentation.

(3) Other PQMP Documentation.

(4) Confirmed Training Orders (CTO) for training conducted by HQ or locally.

D-2. When a FBP requests a change to of their local "home" MEPS and the FBP COR approves the request, the FBP COR will notify the current MEPS, in writing, to send the provider's training folder to the gaining MEPS.

D-3. The provider's training folder, if present, will be stored securely at the MEPS and be accessible to medical staff designated by the MEPS CMO, under Record Number 1aa4/800D, "Employee Records – FBP Qualification and Training File." Upon transfer or termination of a subject individual, the provider's training folder will be kept for three (3) months but no longer than six (6) years, before being destroyed.

Appendix E
Internal Controls Evaluation Checklist – MEPS Medical Department

E-1. Function. The functions covered by this checklist are procedures for MEPS Medical Departments to implement the PQMP.

E-2. Purpose. The purpose of this checklist is to assist Commanders and Medical Departments in evaluating key internal controls listed below. It is not intended to cover all controls. This form should be completed by SMO during a CQA requalification visit which occurs every 1-3 years and by the MEPS as requested.

E-3. Instructions. Answers must be based on actual testing of key internal controls (e.g., document analysis, direct observations, sampling). Answers that indicate deficiencies must be explained and corrective actions indicated in the supporting documentation. These controls must be evaluated at least every two years. Certification that the evaluation has been conducted will be done on DA Form 11-2, Internal Control Evaluation Certification. File completed DA Form 11-2 under RN 11-2a3/800B, "Management Control Program," keep in office file until next management control evaluation, not more than 6 years, then destroy.

E-4. Questions

a. Are government medical providers assigned DPC-1 before being hired? (UMR 40-2, Ch. 2, Ch. 3)

b. Are contract medical providers assigned DPC-1, and received a CAC card before being allowed to train at the MEPS? (UMR 40-2, Ch. 2)

c. Did MHS GENESIS training and access occur prior to initiating PQMP initial training? (UMR 40-2, Ch. 2)

d. Are medical providers performing accession medical services based on their assigned DPC level? (UMR 40-2, Ch. 2)

e. Does the MEPS notify the Command Surgeon's Office of government provider vacancies, hiring actions, interview dates, start dates, and departure dates? (UMR 40-2, Ch. 3)

f. Is required initial training completed and documented and IAW the standard timeline? (UMR 40-2, Ch. 2)

g. Are performance issues documented IAW with UMR 40-2, Ch. 5 and 6?

h. Does the CMO have a peer review program for the local MEPS medical providers? (UMR 40-2, Ch. 5)

i. Are all medical providers actively participating in the local peer review program? (UMR 40-2, Ch. 5)

j. Is the CMO ensuring peer review program documentation is being completed? (UMR 40-2, Ch. 5)

k. Are provider training folders created and maintained IAW UMR 40-2? (UMR 40-2, Ch. 6 and Appendix D)

l. Is all training properly documented IAW UMR 40-2 Ch.5 and Ch. 6?

E-5. Comments
Users may submit comments to HQ USMEPCOM, ATTN: J-3 Medical Branch, 2834 Green Bay Road, North Chicago, IL 60064-3091

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Appendix F
References

Section I
Publications referenced in or related to this publication

OSHA Standard 1910.1030
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AR 11-2
Managers' Internal Control Program

UMR 40-1
Medical Services Medical Qualification Program

UMR 40-8
DoD HIV Testing Program and DAT Program

UMR 40-9
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UMR 601-23
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UMR 690-13
Civilian Personnel Management Program

Section II
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DA Form 11-2-R
Internal Control Evaluation Certification

UMF 40-2-1
Medical Provider Initial Application.

UMF 40-2-2
Malpractice History and Status Questionnaire.

UMF 40-2-3
Provider Clinical Assessment and Qualification.

UMF 40-2-4
Contract Provider Quality Management Form.

Appendix G
Glossary

Abbreviations

A&C
Acquisitions and Contracting Special Staff Office

AANP
American Academy of Nurse Practitioners

ABMS
American Board of Medical Specialties

ACGME
Accreditation Council for Graduate Medical Education

ACMO
Assistant Chief Medical Officer

ACOR
Assistant Contracting Officer Representative

AMA
American Medical Association

ANCC
American Nurse's Credentialing Center

AOiA
American Osteopathic Information Association

AR
Army Regulation

BLS
Basic Life Support

CME
Continuing Medical Education

CMO
Chief Medical Officer

CNP
Certified Nurse Practitioner

COR
Contracting Officer Representative

CQA
Continuous Quality Assessment

CV
Curriculum Vitae (plural)/Curricula Vitae (singular)

CTO
Confirmed Training Order

DA
Department of the Army

DO
Doctor of Osteopathic Medicine

DoD
Department of Defense

DoDI
Department of Defense Instruction

DPC
Defined Provider Category

DP
Defined Provider

ECFMG
Educational Council for Foreign Medical Graduates

FB-CMO
Fee Basis Chief Medical Officer

FBP
Fee Basis Provider

FBPQT
Fee Basis Provider Quarterly Training

fPRP
Formal Provider Review Panel

FQA
Focused Quality Assessment

HQ
Headquarters

IAW
In Accordance With

IPCR
Initial Provider Credential Review

iPRP
Informal Provider Review Panel

IQA
Initial Quality Assessment

J-1
J-1/Human Resources Directorate

J-4
J-4/Facilities and Acquisition Directorate

KO
Contracting Officer

LOR
Letter of Recommendation

MD
Doctor of Medicine

MEPS
Military Entrance Processing Station

MLTS
Medical Leadership Training Symposium

MO
Medical Officer

NCOIC
Noncommissioned Officer in Charge

NP
Nurse Practitioner

NPDB
National Practitioner Data Bank

OGME
Osteopathic Graduate Medical Education

OSHA
Occupational Safety and Health Administration

PA
Physician Assistant

PQMP
Provider Quality Management Program

PSCC
Prescreen Support Coordination Cell

PSO
Prescreen Officer

PRP
Provider Review Panel

PSV
Primary Source Verification

RPS
Remote processing station

RT
Regional Trainer

SMO
Sector Medical Officer

SOP
Standard Operating Procedure

SUP MT
Supervisory Medical Technician

USMEPCOM
United States Military Entrance Processing Command