APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT UPDATE

AUTHORITY: *Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.*

PRINCIPAL PURPOSE: *This evaluation is essential maintaining a qualified, competent medical staff.*

ROUTINE USE: *Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.*

DISCLOSURE IS VOLUNTARY: *However, failure to provide information may result in the limitation or termination of clinical privileges.*

APPLICANT COMPLETES SECTIONS I THROUGH VII

I. IDENTIFICATION *(All date entries must be entered as YYYYMMDD)*

NAME *(Last Name)*	*(First Name)*	*(Middle Name)*	**GRADE**	**DATE** *(YYYYMMDD)*
ALIAS *(i.e., Maiden)*			**SSN**	

HOME ADDRESS *(City, State, and Zip*	**HOME PHONE**	**DUTY PHONE**	**EMAIL ADDRESS**

ORGANIZATION/OFFICE SYMBOL	**DUTY SECTION**	**DAFSC**	**PAFSC**	**CORPS**

II. LICENSE/CERTIFICATION/REGISTRATION, SPECIALTY, AND FEDERAL DEA/STATE CSR *(If additional space is needed, continue in Remarks, Page 3)*

LICENSE/CERTIFICATION/REGISTRATION *(List updates ONLY.)*

STATE LICENSE *(Name of State)*	**STATUS** *(Active, Inactive, Expired, etc.)*	**LICENSE NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**
NATIONAL CERTIFICATION	**STATUS** *(Active, Inactive, Expired, etc.)*	**CERTIFICATE NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**
NATIONAL REGISTRATION	**STATUS** *(Active, Inactive, Expired, etc.)*	**REGISTRATION NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**

SPECIALTY DATA ***(List updates ONLY.)***

SPECIALTY *(List all specialties for which fully qualified)*

BOARD CERTIFICATION *(Specialty Board)*	**STATUS** *(active, inactive, expired, etc.)*	**CERTIFICATE NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**

FEDERAL DRUG ENFORCEMENT ADMINISTRATION ***(DEA)*** **/ STATE CONTROLLED SUBSTANCE REGISTRATION** ***(CSR)*** *(List updates ONLY.)*

FEDERAL DEA *(Type)*	**STATUS** *(active, inactive, expired, etc.)*	**REGISTRATION NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**
DoD Fee-Exempt :				
Federal *(Fee-Paid) :*				
STATE CSR *(Name of State)*	**STATUS** *(active, inactive, expired, etc.)*	**REGISTRATION NUMBER**	**DATE ISSUED**	**EXPIRATION DATE**

III. MEMBERSHIP IN PROFESSIONAL SOCIETIES ***(List updates ONLY.)*** *(If additional space is needed, continue in Remarks, Page 3)*

NAME OF SOCIETY	**STATUS** *(Member, Fellow, etc.)*

IV. REFERENCES *(Every applicant MUST list one peer reference, most recent clinical supervisor, and chief, medical staff (SGH))(List email address if available)*

NAME	**ADDRESS** *(City/Base, State, Zip Code)*	**TELEPHONE/EMAIL ADDRESS**

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT UPDATE *(Continued)*

V. PRACTICE HISTORY *(Explain all "yes" responses in Remarks, Page 3)*

	YES	NO
A. Have there been previously successful or currently pending challenges, revocations, or restrictions to any license, certification, or registration (state, district or Drug Enforcement Administration) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such license, certification, or registration?	☐	☐
B. Have you ever had a voluntary or involuntary limitation, reduction, denial, or loss of clinical privileges?	☐	☐
C. Have you ever voluntarily or involuntarily terminated or been denied medical staff membership or membership in a professional group or society?	☐	☐
D. Have you ever been a defendant in a felony or a misdemeanor? *(Indicate final disposition of case in Remarks, Page 3)*	☐	☐

	YES	NO
E. Have you ever been a defendant or the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication, or any other resolved or unresolved allegations of inappropriate, unethical,	☐	☐
IF "YES" WAS THE RESPONSE:		
(1) Settled prior to final court action?	☐	☐
(2) Judgment rendered by the court?	☐	☐
(3) Defendant found liable?	☐	☐
(4) Matter still pending?	☐	☐

VI. HEALTH STATUS *(Explain all "yes" responses in Remarks, Page 3)*

	YES	NO
A. Do you currently have any physical or mental impairment that	☐	☐
B. Are you currently taking any medications?	☐	☐
C. Do you have a potentially communicable disease?	☐	☐
D. Have you ever been hospitalized for any reason in the past 5	☐	☐

	YES	NO
E. Have you ever been hospitalized for, or diagnosed with, a psychiatric disorder to include substance abuse?	☐	☐
F. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?	☐	☐
G. Have you ever used a controlled substance that was not prescribed for you by a physician or other health	☐	☐

VII. RENEWAL, REVISION OF PRIVILEGES, OR REAPPLICATION *(PCS)*

☐ RENEWAL ☐ REVISION OF PRIVILEGES ☐ REAPPLICATION *(PCS)* *(Check appropriate box indicating reason for completing this form.)*

APPLICANT ACKNOWLEDGMENTS

I HAVE REVIEWED MY CURRENT CLINICAL PRIVILEGES	☐ YES	☐ NO [1]	
I HAVE APPLIED FOR CHANGES I BELIEVE ARE WARRANTED	☐ YES	☐ NO [1]	☐ N/A
I HAVE PARTICIPATED IN OFF-DUTY EMPLOYMENT DURING THIS REVIEW PERIOD *(Active Duty and Civil Service only)*	☐ YES	☐ NO	
IF I PARTICIPATED IN OFF-DUTY EMPLOYMENT, IT WAS APPROVED ACCORDING TO AIR FORCE POLICY *(Active Duty and Civil Service only)*	☐ YES	☐ NO [1]	

VIII. STATEMENT OF APPLICANT *(PLEASE READ CAREFULLY BEFORE*

I certify all information submitted by me in this application is true to the best of my knowledge and belief and I have the ability to perform the clinical privileges requested.

I certify that any false or incomplete information knowingly provided on or with this application may be grounds either for not employing or accessing me or for dismissing or releasing me if I am already employed or serving. I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001.

I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I 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, their staff, and agents. This includes

I consent to the inspection of all records and documents pertinent to my licensure, specific training, experience, current competence, and ability to perform the privileges requested, and, if requested, appear for an interview.

I agree to release and hold harmless from any liability the United States 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.

In making this application for clinical privileges, I acknowledge my responsibility to provide for the continuous care of my patients.

I have been informed that the medical staff bylaws, rules, and regulations (AFI 44-119, Clinical Performance Improvement) can be accessed at the following internet site: http://www.e-publishing.af.mil/ and agree that my activities as a medical staff member will be bound by these

I acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and will cooperate in maintaining JCAHO standards.

I agree to subject my clinical performance to, and faithfully participate in, activities to measure, assess, and improve

SIGNATURE OF APPLICANT	DATE

NOTE: 1 Explain in "Remarks" on page 3.