

APPLICATION FOR PROFESSIONAL STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

From:

To: Professional Affairs,
Via: (1) PROFESSIONAL AFFAIRS COORDINATOR
(2) Appropriate Chain of Command

Subj: STAFF APPOINTMENT WITH CLINICAL PRIVILEGES

Encl: (1) Clinical privilege sheet
(2) Individual Credentials File or Inter-Facility Credentials Transfer Brief,
if ICF is not available

1. Request (see end note; check the applicable paragraph):

___a. Initial staff appointment with clinical privileges as reflected in enclosure (1).

___b. Active staff appointment with clinical privileges as reflected in enclosure (1).

___c. Renewal of active staff appointment with clinical privileges, ___with ___without changes from current privileges, as reflected in enclosure (1).

___d. Affiliate staff appointment with clinical privileges as reflected in enclosure (1).

___e. Modification of clinical privileges as reflected in enclosure (1) to ___add ___delete:

___f. Active staff appointment with clinical privileges as reflected in enclosure (1), based on the active staff appointment with core and supplemental clinical privileges granted at my previous command.

___g. Active staff appointment with clinical privileges, as reflected in enclosure (1), based on the successful completion of my full-time inservice:

- ___ Internship
- ___ Residency
- ___ Fellowship

2. Enclosure (2) provides information in support of this application.

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3. I certify that: (check applicable paragraphs)

___a. I possess the credentials and current clinical competence to justify the granting of the staff appointment with clinical privileges as requested.

___b. I have been provided a copy of or access to, have read, and agree to comply with the facility professional staff policies, procedures, and by-laws.

___c. I have been provided access to and agree to comply with the applicable credentials and privileging directives.

___d. I have no current mental or physical impairment that could limit my clinical abilities.

___e. I will notify the privileging authority and my commanding officer if different from the privileging authority of any change in my mental or physical condition that could limit my clinical ability or performance.

___f. I pledge to provide for the continuous of care for my patients.

___g. To my knowledge, I am not currently under investigation involving substandard clinical practice, malpractice, or personal misconduct.

4. I authorize MIL/MED COMMAND OF SIGNATURE AUTHORITY, LOCATION OF SIGNATURE AUTHORITY OFFICE, its professional staff and legal representatives to evaluate my professional competence, character, and ethical conduct, and to contact and consult with:

___a. Administrators and members of the professional staff of any other treatment facility, institution, or practice with which I have been associated.

___b. Current or past malpractice carriers.

___c. My professional colleagues.

5. I consent to the inspection by MIL/MED COMMAND OF SIGNATURE AUTHORITY, LOCATION OF SIGNATURE AUTHORITY OFFICE, its professional staff, and lawful representatives of all records and documents, including health records at other treatment facilities, that may be material to evaluation of my professional qualifications for staff membership and clinical privileges.

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6. I release from liability all individuals or organizations who respond honestly and in good faith to inquiries authorized in paragraphs 4 and 5.

(Signature) (Date)

Note: Privilege sheets previously approved may be reused when applying for subsequent staff appointments and reappointments if there are no changes in the privileges requested. In such cases, another set of "date requested" and "date approved" blocks must be added to each privilege sheet and completed.

Confirmation of applicants' statement attesting to the ability to perform privileges requested.

Signature

Title

Date