

**THE CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT**

A department of the Naval Healthcare Support Office, Jacksonville, Florida

**Supervisor/Department Head Civilian Employment Inquiry**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

**PURPOSE:** To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

**ROUTINE USE:** Information may be released to government boards or agencies or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

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

**Provider's Name:** \_\_\_\_\_, **Corps:** \_\_\_\_\_, **USNR, SSN/DESIG:** \_\_\_\_\_

**Provider's Primary Specialty:** \_\_\_\_\_

The above named provider is undergoing the credentials review process within the Department of the Navy. We request your conscientious appraisal of the individual's ability to provide quality health care. Please base your evaluation on the provider's demonstrated performance compared to that reasonably expected of a provider with a similar level of training, experience and background within the past two years. An authorization for release of information signed by the provider and a return envelope are enclosed. If this is faxed to you, please fax this completed inquiry back to CCPD at (904) 542-7210/09 promptly. Thank you for your assistance.

**PERSONAL INFORMATION**

1. Have you worked with the provider within the past two years? \_\_\_\_\_
2. How long have you known the provider? \_\_\_\_\_
3. What is your relationship with the provider? \_\_\_\_\_

**FACILITY DEMOGRAPHICS**

Name of Facility: \_\_\_\_\_

Department: \_\_\_\_\_

Provider's Position and Clinical Assignment: \_\_\_\_\_  
 \_\_\_\_\_ Clinical \_\_\_\_\_ Administrative

**SCOPE OF CLINICAL RESPONSIBILITY**

Major Population Served: \_\_\_\_\_

Age/Sex/Unique features of population served (geriatric, pediatric, etc.) \_\_\_\_\_

Acuity Level: \_\_\_\_\_

Average Length of Stay for major population served: \_\_\_\_\_

Average Outpatient visits: \_\_\_\_\_

Unit Specific Competencies: \_\_\_\_\_

**CLINICAL PERFORMANCE**

Check Satisfactory, Unsatisfactory, or Not Observed

<b>Evaluation Elements</b>	Satisfactory	Unsatisfactory	Not Observed
A. Basic Professional Knowledge	_____	_____	_____
B. Technical Skill/Competence	_____	_____	_____
C. Professional Judgment	_____	_____	_____
D. Ethical Conduct	_____	_____	_____
E. Participation in staff/department/committee meetings	_____	_____	_____
F. Ability to work with peers and support staff	_____	_____	_____
G. Ability to supervise peers and support staff	_____	_____	_____

## Supervisor/Department Head Civilian Employment Inquiry

**Provider's Name:** \_\_\_\_\_, **Corps:** \_\_\_\_\_, **USNR, SSN/DESIG:** \_\_\_\_\_

**Provider's Primary Specialty:** \_\_\_\_\_

**OTHER INFORMATION**

Note: If any question is circled "YES", please provide full details in the comment section or attach a separate sheet. To your knowledge, during this period, has this nurse:

	Circle	YES	or	NO
1. Had licensure/clinical certification of functions been <b>voluntarily</b> or <b>involuntarily</b> denied, suspended, limited, or revoked?		Yes		No
2. Received a formal letter of warning regarding clinical performance?		Yes		No
3. Been the primary subject of a malpractice action, claim, investigation, or health care review inquiry?		Yes		No
4. Had sub-standard care substantiated through one of the actions above?		Yes		No
5. Required counseling, additional training, or special supervision in response to performance, quality, or legal problems?		Yes		No
6. Failed to obtain appropriate consultation?		Yes		No
7. Required modification of job assignment due to health status?		Yes		No
8. Been diagnosed as being alcohol and/or drug dependent or having any organic mental or psychotic disorder?		Yes		No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Describe trends, positive or negative, identified through the facility process/quality improvement program. Please comment on provider's clinical abilities.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**GENERAL IMPRESSION**

My general impression of the provider is \_\_\_\_\_

**RECOMMENDATION**

     **Recommend without reservation**

     **Recommend with reservation**  
(Explain on separate sheet)

     **Do not recommend**  
(Explain on separate sheet)

Printed name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Institution \_\_\_\_\_ Position \_\_\_\_\_ Specialty \_\_\_\_\_

Is there anything you would like to discuss with us over the phone? If yes, please call (800) 566-8494, extension 8115 or 8116. Thank you.