

THE CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT

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

Civilian Employment Credential/Privileging 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 within your facility. 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. Core privilege sheets identifying the provider's area of specialty and 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.

SCOPE OF CARE

1. Privileges that the provider holds at your facility.

2. Volume data for **past 2 years**

- (a) # of admissions or outpatient encounters _____
- (b) # of days unavailable (i.e. conferences, illness, vacation) _____
- (c) # of major procedures or encounters _____

CURRENT COMPETENCE (comments)

1. Professional (**past 2 years**) (i.e. number of cases, records reviewed, and cases outside standards)

(a) Surgical/invasive/noninvasive case reviews. _____

(b) Blood usage review. _____

(c) Drug usage review. _____

(d) Medical record pertinence review. _____

(e) Medical record peer review. _____ # reviewed _____ # deficient

2. Facility-wide monitors (**past 2 years**) (circle appropriate mark)

- (a) Utilization review. Satisfactory Unsatisfactory
- (b) Infection control. Satisfactory Unsatisfactory
- (c) Patient contact/satisfaction program Satisfactory Unsatisfactory
- (d) Number of liability claims, investigation, and healthcare reviews in which practitioner was principle focus. _____

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3. Evaluation: If you answer "**NO**" to any of these questions **a-k below**, please provide full details on a separate attached sheet.

"**YES**" for Meets Community Standards "**NO**" for Does not Meet Community Standards "**UNK**" for unknown

	YES	NO	UNK
(a) Basic Professional Knowledge	_____		
(b) Technical Skill	_____		
(c) Clinical Competence	_____		
(d) Professional Judgement	_____		
(e) Ethical Conduct	_____		
(f) Practitioner/Patient Relationship	_____		
(g) Participation in Medical Affairs	_____		
(h) Practitioner-Peer Relationship	_____		
(i) Practitioner-Staff Relationship	_____		
(j) Patient Care	_____		
(k) Quality & Completion of Health Records	_____		

4. Professional development (**past 2 years**)

- (a) # of continuing education credit hours. _____
- (b) # of papers published and professional presentations. _____

HEALTH STATUS INQUIRY (circle appropriate mark)

Does the provider have a physical or mental condition, which could affect his/her ability to perform professional skills or would require an accommodation in order to perform professional skills safely and competently? **YES** **NO**

ADVERSE ACTIONS OR TRENDS (circle appropriate mark)

If you answer "**YES**" to questions **1-6 below**, as they pertain to your facility only, please provide full details on separate attached sheet. Has applicant:

- (a) Had privileges adversely denied, suspended, limited or revoked? **YES** **NO**
- (b) Had privileges nonadversely reduced? **YES** **NO**
- (c) Required counseling, additional training, or special supervision? **YES** **NO**
- (d) Failed to obtain appropriate consultation? **YES** **NO**
- (e) Had significant trends (**positive or negative**) in clinical performance? **YES** **NO**
- (f) Been under investigation by any governmental or other legal body? **YES** **NO**

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Provider's Primary Specialty: _____

SUMMARY RECOMMENDATION

_____ **Recommend without reservation**

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

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

We thank you for your objective response to these questions. On a separate sheet, please provide your candid evaluation of this practitioner's clinical competency, as you have observed, and any other comments that will assist in this evaluation. For questions or comments about this inquiry, you may call our office at (800) 566-8494 extension 8116 or 8115.

Printed name _____ Signature _____ Date _____

Institution _____ Position _____

Specialty _____