APPROVAL OF CLINICAL PRIVILEGES/STAFF APPOINTMENT

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSN	4. EFFECTIVE PERIOD *(YYYYMMDD)* FROM TO

5. PRIVILEGES REQUESTED. *(Specify discipline(s))*

☐	a. Aerospace medicine	☐	k. Neurology	☐	u. Physician assistant
☐	b. Anesthesia	☐	l. Nurse anesthesia	☐	v. Podiatry
☐	c. Audiology	☐	m. Nurse midwifery	☐	w. Psychiatry
☐	d. Chiropractic	☐	n. Nurse practitioner	☐	x. Psychology
☐	e. Clinical pharmacy	☐	o. Obstetrics and gynecology	☐	y. Radiology/Nuclear medicine
☐	f. Dentistry	☐	p. Occupational therapy	☐	z. Social work
☐	g. Dietetics	☐	q. Optometry	☐	aa. Speech pathology
☐	h. Emergency medicine	☐	r. Pathology	☐	ab. Surgery
☐	i. Family practice	☐	s. Pediatrics	☐	ac. Other *(Specify)*
☐	j. Internal medicine	☐	t. Physical therapy		

6. RECOMMENDATIONS. The following department/service and credentials committee/function recommendations are based on a review of the provider's verified licensure, education and training, experience, physical and mental capabilities to perform the requested privileges and demonstrated current competence. Exceptions or stipulations are noted below in block 7.

a. MEDICAL TREATMENT FACILITY/DENTAC *(Name and location)*	b. APPOINTMENT STATUS	c. CATEGORY OF PRIVILEGES
	☐ Initial ☐ None ☐ Active ☐ Affiliate ☐ Temporary	☐ Regular ☐ Supervised ☐ Temporary

d. ADMITTING PRIVILEGES	e. PLAN OF SUPERVISION	f. NAME OF SUPERVISOR *(If applicable)*
☐ Requested ☐ Granted ☐ Not requested ☐ Not granted	☐ Required ☐ Not required	

g. AGE GROUPS: *(Check all that apply.)* ☐ Neonates (Birth - 28 days) ☐ Infants (1-24 mos) ☐ Children (2-12 yrs) ☐ Adolescents (13-17 yrs) ☐ Young Adults (18-23 yrs) ☐ Adults (24-65 yrs) ☐ Geriatrics (> 65 yrs)

h. DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	i. SIGNATURE	j. DATE *(YYYYMMDD)*

k. The credentials committee (other committee designated this function) met _____ to review the merits of this provider's application for staff appointment and/or clinical privileges. It is the decision of this committee to

☐ CONCUR ☐ NOT CONCUR with the above recommendations. Exceptions or stipulations are noted below in block 7.

l. COMMITTEE CHAIRPERSON *(Name, rank, and title)*	m. SIGNATURE	n. DATE *(YYYYMMDD)*

7. REMARKS

8. The Executive Committee of the Medical/Dental Staff (ECMS/ECDS) reviewed this provider's request for privileges and medical staff appointment, as applicable, on _____ . Recommendation to ☐ GRANT ☐ NOT GRANT this provider medical staff appointment and/or clinical privileges is hereby forwarded to the MTF commander.

8a. ECMS/ECDS CHAIRPERSON *(Name and rank)*	8b. SIGNATURE	8c. DATE *(YYYYMMDD)*

9. APPROVAL. Based on my review of the information submitted in support of the provider's licensure, education and training, and his/her demonstrated competence, privileges are approved and medical staff membership is awarded as requested. The period for which clinical privileges and staff membership are in effect is as noted above in Block 4.

9a. NAME OF MTF COMMANDER	9b. COMMANDER'S SIGNATURE	9c. DATE *(YYYYMMDD)*