DELINEATION OF CLINICAL PRIVILEGES - PHYSICIAN ASSISTANT

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. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

GENERAL: Physician Assistants will demonstrate skills in interviewing, examination, assessment, and management of patients with general medical, obstetrical, surgical, and psychiatric health problems. Seriously ill patients will be managed in consultation with or direct referral to appropriate medical specialists.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Category I. Primary Care.

Ambulatory care for soldiers, family members and other beneficiaries that involves uncomplicated illnesses or problems with low risk to patients. These duties will typically be performed in Troop Medical Clinics, Ambulatory Patient Care Clinics, or Outpatient Clinics.

Requested	Approved	
		Category I clinical privileges
		a. Diagnose and treat illnesses and injuries (all categories of beneficiaries)
		b. Order and interpret laboratory tests
		c. Order and interpret radiographs (X-ray, CT, MRI and Ultrasound)
		d. Prescribe and/or administer P&T Committee approved medications
		e. Issue temporary profiles (not to exceed 30 days)
		f. Perform complete histories and physicals (AR 40-501)
		g. Supervision of immunizations (AR 40-562)
		h. Nuclear and Chemical Surety evaluations (AR 50-5 and 50-6)

Category II. Specialty Areas. Includes Category I.

Requires residency or specialty training that prepares the physician assistant to perform duties, procedures or manage specific categories of patients.

Requested	Approved		Requested	Approved	
		Category II clinical privileges			f. Cardio-thoracic Surgery
		a. Aviation Medicine (Aeromedical PA)			g. Diving/Hyperbaric Medicine (DMO/HMO)
		b. Orthopedics			h. Neurosurgery
		c. Emergency Medicine			i. Dermatology
		d. Occupational Medicine			
		e. Cardiovascular Perfusion			

Category III. Procedures. Includes Categories I and II.

Requested	Approved		Requested	Approved	
		Category III clinical privileges			e. Administration of IV fluids
		a. Joint aspiration/injection			f. Nasogastric intubation
		b. Wound care, debridement and suturing			g. Nasopharyngeal intubation
		c. Incision and drainage of abscesses			h. Stabilization of fractures
		d. Urethral catheterization			i. Reduction of simple extremity fractures

Category III. *(Continued)*

Requested	Approved		Requested	Approved	
		j. Administration of anesthesia			k. First assist in major surgical cases
		(1) Digital			
		(2) Local			
		(3) Intercostal			

Category IV. Inpatient Privileges. Includes Categories I, II and III.
Typically requires specialty training or assignment to duties that necessitate these privileges.

Requested	Approved		Requested	Approved	
		Category IV clinical privileges			d. *Narrative summaries
		a. *Admission of patients			e. *Discharge of patients
		b. *Inpatient history and physical examinations			
		c. *Doctor's orders			

*Requires physician review and signature within 24 hours.

COMMENTS

	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNAURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*