



DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
550 POPE AVENUE
FORT LEAVENWORTH, KANSAS 66027-2332

REPLY TO
ATTENTION OF:

S:

MCXN-COD (40-68)

MEMORANDUM FOR

SUBJECT: Update of Credentials

1. In accordance with AR 40-68, Practitioner Credentials Files (PCFs) and Practitioner Activity Files (PAFs) must be established, maintained, and updated periodically to ensure that credential documents are kept current.

2. To establish/update your PCF and PAF, please provide the information/documents checked below:

- Diploma from medical/dental school (certified true copy/prime source verified)
- ECFMG (if foreign graduate) (certified true copy/prime source verified)
- Internship certificate (certified true copy/prime source verified)
- Residency certificate (certified true copy/prime source verified)
- Fellowship certificate (certified true copy/prime source verified)
- Specialty board certificate (certified true copy/prime source verified)
- Evidence of current state license (certified true copy/prime source verified)
- Evidence of an original state license certificate (certified true copy)
- Controlled substances certificate from the Drug Enforcement Agency (DEA)
- Curriculum vitae to account for ALL periods of time subsequent to obtaining your medical/dental degree
- Two letters of reference from physicians qualified to evaluate your performance of work, including one from an official at the institution where you previously had or currently have clinical privileges
- Evidence of Certification in CPR (certified true copy)
- Evidence of training in Advance Cardiac Life Support, Advanced Trauma Life Support, and/or Pediatric Advanced Life Support (if applicable) (certified true copy)
- Proof of required malpractice insurance
- Statement of current employment
- Statement of current mental and health status
- Attachments

EDITH L. COTTON
Credentials Coordinator

CURRICULUM VITAE

NAME:

RANK:

SOCIAL SECURITY:

OBC DATE (Military):

HOME ADDRESS:

HOME PHONE:

DATE OF BIRTH:

PLACE OF BIRTH:

MARITAL STATUS:

SPOUSE (NAME):

CHILDREN:

EDUCATION

UNDERGRADUATE:

GRADUATE:

INTERNSHIP:

RESIDENCY:

CERTIFICATIONS:

PROFESSIONAL SOCIETIES:

PROFESSIONAL ASSIGNMENTS:

AWARDS:

PUBLICATIONS:

DELINEATION OF PRIVILEGES RECORD

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

I. PERIOD
FROM TO

2. Check the Appropriate Category

A. Anesthesia	I. Pediatrics	O. Nurse Practitioners (Adult)
B. Dentistry	J. Podiatry	R. Nurse Practitioners (Pediatric)
C. Family Practice	K. Psychiatry	S. OB/GYN Nurse Practitioners
D. Internal Medicine & Subspecialty	L. Psychology	T. Physician Assistants
E. Neurology	M. Radiology/Nuclear Medicine	U. Emergency Medicine
F. Obstetrics & Gynecology	N. Surgery	V. Other Specialty (Specify)
G. Optometry Service	O. Nurse Anesthetists	
H. Pathology	P. Nurse Midwives	

3. Recommendations

A. MEDICAL TREATMENT FACILITY/IDENTAC Munson Army Health Center Fort Leavenworth, KS 67207-2332		B.	C. CLINICAL PRIVILEGES <input type="checkbox"/> (1) Granted as Requested <input type="checkbox"/> (2) Modified as Recommended <input type="checkbox"/> (3) Other (See Remarks)	
D. DEPT./SVC (Specify)	E. DATE	G. CREDENTIALS COMMITTEE	H. DATE	
F. SIGNATURE		I. SIGNATURE		

4. Approval

A. NAME OF HOSPITAL/IDENTAC COMMANDER	B. SIGNATURE	C. DATE
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5. Remarks

In making this recommendation the provider's verified licensure, education and training, experience, capability to perform the required privileges, and demonstrated current competence have been reviewed by the Credentials Committee and the Dept/Service Chief of the specialty in which the practitioner is requesting privileges:

1. Admitting Privileges: Granted Not Granted .
2. Appointment Type: Initial Active Affiliate Temporary No Appointment
3. Privilege Category: Regular Temporary *Supervised

*See attached written plan of supervision. Not to exceed 24 months

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM (Date)	B. BOARD EXAMINATION TAKEN (Date) <input type="checkbox"/> Total <input type="checkbox"/> Partial	C. BOARD CERTIFIED <input type="checkbox"/> No <input type="checkbox"/> Yes (Give Name of Board)
D. RECERTIFICATION (Board and Date)	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING (Specify only training since initial application)
G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD (Specify)	J. NAME OF APPLICANT OR PRACTITIONER
I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) (Specify)	K. SIGNATURE	L. DATE

MCXN-COD

Date: _____

MEMORANDUM THRU Chief, Department of _____

FOR Credentials Committee

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment (if applicable)

1. I request an appointment to the medical staff of Munson Army Health Center, Fort Leavenworth, KS and clinical privileges as specified on the enclosed DA Form 5440-series; Delineation of Privileges form.
2. I certify that I possess the necessary skills and expertise to justify granting of clinical privileges in those areas I have indicated on the forms, and that I am clinically competent to perform in those areas.
3. If any change in my mental or physical state occurs during a privileging period, I will immediately, or as soon as I am physically able, notify a designated supervisor.
5. This request is accompanied by the documents required for the credentials review for medical staff appointment and clinical privileging.
4. I certify that I am currently in good health, that I am able to perform the privileges requested, with or without reasonable accommodation, and that I do not have any physical or mental conditions which could preclude or affect my performance in providing the requested health care services. I do not have and have not had any significant illness(es) including psychiatric and alcohol/drug abuse, nor have I had any major surgical procedures that would impact, prevent or preclude my performance, except as listed below:

Printed Name

Signature

Date

1st End: Physician Supervisor

To the best of my knowledge, the above information stated in question #4 is correct.

Physician's Printed Name

**RELEASE OF INFORMATION
AND
CONTINUOUS CARE PLEDGE**

By applying for clinical privileges at Munson Army Health Center (MAHC), I pledge that I will, to the maximum extent possible, provide continuous care to my patients and will refrain from delegating the responsibility for diagnosis or care of patients to another health care provider who is not qualified to undertake that responsibility and/or who is not adequately supervised.

I understand that clinical privileges are granted by the Commander of MAHC and are contingent upon me abiding by the rules, regulations and policies as currently written or as hereafter amended. This includes, but is not limited to, elements defined in Army Regulation 40-68, MEDDAC Regulation 40-50, Joint Commission on Accreditation of Health Care Organizations and the MACH Quality Assurance/Management Program. I have been given an opportunity to read the documents specified above, or acknowledge having been provided a copy of same.

I hereby release from any liability all representatives of Munson Army Health Center, Fort Leavenworth, Kansas its employees and members of the medical staff for their acts performed in good faith and without malice in connection with evaluation of my application for clinical privileges and review of my credentials. I also release from any liability any and all individuals and organizations who provide information to Munson Army Health Center, in good faith and without malice, concerning my competence, ethics, character and other qualifications for staff appointment and clinical privileges. This release includes otherwise privileged or confidential information concerning my education, training, experience, competency, licensure, board membership certification, continuing education, physical or mental status peer recommendations, malpractice history, past and current clinical privileges held and performed, assessments of clinical skills, ability and judgment, communication skills, rapport with patients and colleagues, professional or ethical conduct, and adherence to facility and departmental Quality Assurance/Management Programs, protocols and policies.

I understand that any significant misstatements or omissions from my application and any allied documents submitted therewith constitutes cause for denial of clinical privileges or withdrawal of clinical privileges. All information submitted in my application is true to the best of my knowledge.

Date

Signature

Date of Birth

Printed Name

A copy of this Release of Information and Continuous Care Pledge shall be as binding as the original.