DELINEATION OF CLINICAL PRIVILEGES - PATHOLOGY

(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.

PROVIDER CODES	APPROVAL 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	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Category I.
Successful completion of an accredited training program in anatomic or clinical pathology or both.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.
Board certification in anatomic or clinical pathology, or both, as determined by the American Board of Pathology.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.
Board certification in anatomic or clinical pathology, or both, as determined by the American Board of Pathology and,
- Subspecialty fellowship certificate issued upon successful completion of a fellowship training program in any subspecialty accredited by American Board of Pathology, or
- Subspecialty board certification in a sub-discipline of anatomic or clinical pathology as determined by the American Board of Pathology.

Requested	Approved	
		Category III clinical privileges

ANATOMIC PATHOLOGY

Requested	Approved	
		a. Surgical Pathology
		(1) Gross and microscopic examination of tissue with preparation of written report
		(2) Intraoperative consultation/with frozen section preparation and issue of written report
		(3) Interpretation of special stains
		b. Dermatopathology
		c. Electron Microscopy
		d. Forensic Pathology
		e. Neuropathology
		f. Pediatric Pathology
		g. Autopsy Pathology
		(1) Dissection and interpretation of gross findings
		(2) Interpretation of microscopic findings and special studies with preparation of written report
		h. Cytopathology
		(1) Evaluation of gynecologic cytology with preparation of written report
		(2) Evaluation of non-gynecologic cytology with preparation of written report
		(3) Performance/interpretation of fine needle aspiration with preparation of written report

CLINICAL PATHOLOGY

NOTE: For each of the sub-specialties associated with Clinical Pathology, as noted below, the provider must demonstrate proficiency in: management/administration, evaluation of QA procedures and compliance with applicable regulations and standards, acquisition and evaluation of equipment/methods, clinical correlation of tests, and consultation (verbal/written).

Requested	Approved		Requested	Approved	
		a. Clinical Chemistry			h. Hematopathology. Evaluation and interpretation of findings with preparation of written report for:
		b. Blood Banking			
		(1) Transfusion Medicine			(1) Peripheral blood
		(2) Donor Center Operations			(2) Bone marrow
		c. Clinical Microscopy			(3) Body fluids
		d. Medical Microbiology			(4) Special coagulation problems
		e. Serology/Immunopathology			
		f. Flow Cytometry			
		g. Molecular and Genetic Pathology			

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)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE RECOMMENDATION

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

COMMENTS

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