APPLICATION FOR RENEWAL OF CLINICAL PRIVILEGES AND STAFF APPOINTMENT

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

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: Title 5, United States Code (USC), Sections 301 and 552a; Title 44, USC, Section 3101; Title 10, USC, Section 1071.

Principal Purpose: To document the provider's professional qualifications as the basis for clinical privileges and staff appointment.

Routine Uses: To support the credentialing and privileging processes. A copy of this form will be retained in provider credentials file. Information may be provided to certain civilian institutions, the Federation of State Medical Boards of the U.S., State Licensure Authorities, and other appropriate professional regulatory bodies.

Disclosure: Disclosure of information requested is voluntary. However, failure to provide the required information may interfere with the timely granting of your clinical privileges or professional staff appointment.

INSTRUCTIONS. This form is to be completed by all providers (military/civilian) who are requesting renewal of clinical privileges and/or reappointment to the medical/dental staff. The information provided herein is to update that contained on DA Form 4691.

SECTION I - IDENTIFICATION

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSAN	4. DATE OF BIRTH *(YYYYMMDD)*

5. SPECIALTY/AOC	6. MEDICAL/DENTAL FACILITY *(Name and Address: City/State/ZIP Code)*

SECTION II - PROFESSIONAL EDUCATION

7. EDUCATIONAL DATA.
List residency training, fellowships, any formal schools attended, etc., **since your previous application for privileges.**

7a. INSTITUTION	7b. ADDRESS *(City/State)*	7c. PROGRAM	7d. FROM/TO *(YYMM-YYMM)*

8. BOARD STATUS.
Have you passed a professional specialty board or re-boarded **since your previous application for privileges?** ☐ NO ☐ YES ☐ N/A

8a. DATE TAKEN *(YYYYMMDD)*	8b. SPECIALTY BOARD	8c. EXPIRATION DATE *(YYYYMMDD)*

9. CERTIFICATION DATA.
Have you passed a professional specialty certification examination **since your previous application for privileges?** ☐ NO ☐ YES

9a. DATE TAKEN *(YYYYMMDD)*	9b. CERTIFYING ORGANIZATION	9c. EXPIRATION DATE *(YYYYMMDD)*

10. CONTINUING EDUCATION.
Total hours of CME/CDE or other professional education attended **since your previous application for privileges** _____ .

11. CURRENT PROFESSIONAL ASSOCIATIONS. *(Indicate memberships.)*	12. CURRENT TEACHING APPOINTMENTS. *(Note appointments or positions.)*

13. OTHER PROFESSIONAL RECOGNITION. *(Please specify recognition received since your last application for privileges.)*

SECTION III - LICENSURE/CERTIFICATION/REGISTRATION

14a. STATE LICENSING/AUTHORIZING AGENCY	14b. NUMBER	14c. EXPIRATION DATE *(YYYYMMDD)*

15a. DEA/CDS REGISTRATION *(Specify state as applicable.)*	15b. NUMBER	15c. EXPIRATION DATE *(YYYYMMDD)*

16a. CERTIFICATION	16b. ISSUED BY	16c. EXPIRATION DATE *(YYYYMMDD)*
BLS		
ACLS		
ATLS		

SECTION IV - CLINICAL PRIVILEGES REQUESTED

17. I attest that based on my professional qualifications and credentials, I am clinically competent to fully perform the clinical privileges for which I am applying. I request renewal of my clinical privileges as specified on attached DA Form 5440-series appropriate to my discipline.
Type of privileges requested: ☐ Regular ☐ Temporary ☐ Supervised

18. I request reappointment to the medical/dental staff in the following category:
☐ Active ☐ Affiliate ☐ Temporary ☐ No Appointment

19. I request admitting privileges.
☐ YES ☐ NO

20. I request to manage and treat patients in 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)

SECTION V - COMMENTS

21. Provide explanation or additional details for any of the numbered items above. *(Note item number.)*

22. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge.

	22a. SIGNATURE OF PROVIDER	22b. DATE *(YYYYMMDD)*