DELINEATION OF CLINICAL PRIVILEGES - CHIROPRACTIC

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

1. NAME OF PROVIDER *(Last, First, MI)*	2. 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	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	5 - Not approved, insufficient facility support

SECTION I - CLINICAL PRIVILEGES

Chiropractic care providers will demonstrate skills in history taking, physical examination, neuromusculoskeletal/chiropractic examination, psychosocial assessment, and management of patients with neuromusculoskeletal problems. Full privileges will include management of referred patients having neuromusculoskeletal conditions. Assignment of clinical privileges will be based on the chiropractor's education, clinical training, and demonstrated competence.

Requested	Approved	
		a. Provide chiropractic health care and services, as taught in the core curriculum of a Council on Chiropractic Education (CCE) accredited chiropractic college, to eligible active duty DoD beneficiaries.
		b. Perform routine manual and mechanical, osseous and soft tissue chiropractic procedures for axial neuromusculoskeletal disorders or complaints.
		c. Perform routine manual and mechanical, osseous and soft tissue chiropractic procedures for non-axial neuromusculoskeletal disorders or complaints.
		d. Conduct psychosocial and biophysical patient history and chiropractic physical examination (excluding vaginal examination) using methods, techniques and instruments standard to all medical professions. This examination includes postural and spinal analysis unique to chiropractic diagnosis.
		e. Order standard diagnostic plain film radiological examinations to include: spine (4 views), skull series, chest (PA and lateral views), rib series, and pelvis films.
		f. Order standard diagnostic laboratory tests to include: electrolyte profile, CBC, ESR, urinalysis, urine culture/sensitivity, and stool for occult blood.
		g. Utilize the therapeutic modalities of heat, cold, light, electricity, ultrasound, hydrotherapy, and other procedures in patient treatment, as appropriate, with referral to MTF specialty services as clinically indicated for specialty consultation and/or diagnostic studies.
		h. Recommend temporary limited duty profiles for AD personnel IAW AR 40-501.
		i. Assign AD patients to quarters as clinically indicated for up to 72 hours IAW AR 40-66.
		j. Provide instruction and recommendations regarding hygiene, basic nutrition, exercise, life style changes, stress reduction, and modification of ergonomic factors in the activities of daily living.
		k. Order orthotic devices, materials and appliances that are available through the MTF and commonly used in the chiropractic profession.

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/FUNCTION RECOMMENDATION

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

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