DELINEATION OF CLINICAL PRIVILEGES - ORTHOPAEDICS

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	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

Requested	Approved		Requested	Approved	
		a. Amputation, major			r. Osteomyelitis and septic arthritis, drainage of
		b. Arthrocentesis			s. Prosthetic replacement of bones and joints
		c. Arthroscopy, diagnostic and surgical			t. Release and/or excision of muscles, tendons, fascia, ligaments and nerves
		d. Arthrodesis			u. Reimplantation of severed digits using microvascular technique
		e. Arthroplasty			v. Scoliosis and kyphosis, surgical correction with or without posterior instrumentation
		f. Arthrotomy			w. Scoliosis and lordosis, surgical correction with or without anterior instrumentation
		g. Bone graft procedures			x. Skeletal defects:
		h. Bone and muscle transposition to restore function or form of extremities			(1) Intercalary reconstruction of segmental defects
		i. Excision of:			(2) Reconstruction using synthetic or metal materials
		(1) Bursae, calcium deposits, soft tissue tumors of extretity			y. Tendon grafts with or without preliminary silastic tendon prosthesis
		(2) Herniated nucleus pulposus			z. Tendon repair, transfer, lengthening or shortening
		(3) Degenerated intervertebral disc			aa. Ligament repair and reconstruction - hand, knee, ankles, shoulders, and elbows
		(4) Bone tumors			ab. Nerve:
		j. Flaps, local and distant microvascular free			(1) Transplantation
		k. Fractures and dislocations, open and closed reduction of major injuries, including skeletal traction, and internal and external fixation			(2) Grafts
		l. Fusion of spine:			(3) Repair
		(1) Anterior, posterior cervical			ac. Open and closed cervical, thoracic, and lumbar discectomy/disc injection or ablation
		(2) Anterior, posterior thoracic			ad. Use of cement, i.e., methyl methacrylate, with or without prosthetic use
		(3) Anterior, posterior lumbar			ae. Anesthesia, low and regional blocks
		m. Grafts, split thickness skin			af. Lumbar puncture
		n. Grafts, full thickness and pedicle			ag. Myelography
		o. Laminectomy			
		(1) Cervical			
		(2) Thoracic			
		(3) Lumbar			
		p. Manipulation of deformities of musculo-skeletal system			
		q. Osteotomy			

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)*