EVALUATION OF CLINICAL PRIVILEGES - FAMILY PRACTICE

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. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/ZIP Code)*	

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, line through and initial any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION

CODE	CATEGORY/PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	a. Anoscopy			
	b. ECG Performance and Initial Interpretations			
	c. Basic Radiologic Interpretations *(Skull, spine, CXR, abdomen, IVP, and extremity)*			
	d. Insertion/Removal of IUD			
	e. Regional Anesthesia			
	f. Splinting/Casting/Immobilizing of Simple Fractures			
	Category II clinical privileges			
	a. Lumbar Puncture *(Adult and Child)*			
	b. Infant/Newborn Resuscitation			
	c. Vaginal Delivery *(Uncomplicated)*			
	d. Endometrial Biopsy			
	e. Circumcision *(Infant)*			
	f. Breast Mass/Cyst Aspiration			
	g. Nasopharyngoscopy			
	h. Procto-/Flexible Sigmoidoscopy			
	i. Minor Surgery			
	Category III clinical privileges			
	a. Joint Aspiration/Injection			
	b. Diagnostic Thoracentesis With or Without Biopsy			
	c. Abdominal Pericentesis			
	d. Bone Marrow Aspiration and Biopsy			
	e. Low Forceps Delivery			
	f. Vacuum Extraction			
	g. Obstetrical Anesthesia			
	h. Obstetrical Ultrasound, Limited *(Describe)*			
	i. Vaginal Birth After Cesarean (*VBAC)*			
	j. Dilation & Curettage			
	k. Colposcopy, Diagnostic/Therapeutic/LEEP			
	l. Insert/Remove Norplant Device			
	m. First Assist at Major Surgical Procedures			

CODE	CATEGORY/PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	n. Reduction of Simple Extremity Fractures			
	o. Vasectomy			
	p. Treadmill Stress Testing *(Thallium, etc.)*			
	q. Arterial Line Placement			
	r. Central Line Placement			
	Category IV clinical privileges			
	a. Pulmonary Artery Catheterization			
	b. Management of Severe Pre-eclampsia			
	c. Ventilator Management			

SECTION II - COMMENTS ***(Explain any rating that is "Unacceptable".)***

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*