MALPRACTICE HISTORY AND CLINICAL PRIVILEGES QUESTIONNAIRE

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 health care providers (military/civilian) upon initial entry or re-entry into Federal Service, and as part of the periodic clinical privileges renewal process.

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

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

6. Place a check (X) in the column that corresponds to your answer to each of the following questions. *(Any "YES" answer must be fully explained on the bottom of this page in block 8.)* Note: An answer is required for every question.

YES	NO	ARE YOU NOW OR HAVE YOU EVER:
☐	☐	a. Been required to appear before any medical or State regulating authority, regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?
☐	☐	b. Had a history of alcohol or other drug abuse or misuse?
☐	☐	c. Had your narcotics registration suspended or revoked?
☐	☐	d. Had your professional privileges voluntarily or involuntarily denied, revoked, suspended, reduced, or restricted by a health care facility?
☐	☐	e. Had your request for any specific clinical privilege(s) denied or granted with specific limitations?
☐	☐	f. Voluntarily or involuntarily resigned or otherwise disassociated yourself from employment or practice after being notified of the intent to initiate action against you for failure to properly execute your professional responsibilities?
☐	☐	g. Had medical liability claims, settlements, judicial or administrative adjudications, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard professional practice?
☐	☐	h. Had your professional license voluntarily or involuntarily denied, restricted, withdrawn, suspended, or revoked by a State or local licensing board or other authority?
☐	☐	i. Been asked to voluntarily surrender your license?
☐	☐	j . Had a previously successful or currently pending challenge(s) to any license or registration (e.g., State or District, Drug Enforcement Agency, etc.) that you hold now, or have held?
☐	☐	k. Been refused membership in an institution's medical or dental staff?
☐	☐	l. Been denied membership, or renewal thereof, or been subject to disciplinary action in any medical/dental organization?
☐	☐	m. Been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance programs (i.e., Medicare or Medicaid)?
☐	☐	n. Had your professional liability coverage canceled, limited, denied, or not renewed?

7. COMMENTS. Note item by number *(6a. - 6n.)* and provide clarification of any question with a "YES" answer. Include clarification for any circumstance not already addressed in detail on a previous DA Form 5754. *(Continue on a separate page.)*

8. HEALTH STATUS. Provide a brief description of your current physical and mental health status and your ability to perform the clinical privileges appropriate to your discipline.

9. MALPRACTICE INSURANCE. Initial applicants address past 10 years, all others list only current carriers.

a. CARRIER *(Current and previous)*	b. ADDRESS *(Street/City/State/ZIP Code)*	c. POLICY NUMBER

10. CLINICAL PRIVILEGES. Initial applicants address past 10 years, all others list the hospitals/institutions where privileges are currently held.

a. HOSPITAL/INSTITUTION	b. ADDRESS *(Street/City/State/ZIP Code)*	c. FROM/TO *(YYMM-YYMM)*

11. I hereby certify that the information contained herein is true, accurate, and complete to the best of my knowledge. I hereby authorize the U.S. Army to contact the malpractice carriers and the hospitals/institutions listed above for the purpose of verifying the information provided.

a. SIGNATURE OF PROVIDER	B. DATE *(YYYYMMDD)*