

## LIST OF CLINICAL PRIVILEGES – CHIROPRACTIC

**AUTHORITY:** Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.

**PRINCIPAL PURPOSE:** To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.

**ROUTINE USE:** Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.

**DISCLOSURE IS VOLUNTARY:** However, failure to provide information may result in the limitation or termination of clinical privileges

### INSTRUCTIONS

**APPLICANT:** In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect your current capability. Sign and date the form and forward to your Clinical Supervisor

**CLINICAL SUPERVISOR:** In Part I, using the facility master privileges list, enter Code 1, 2, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form and forward the form to the Credentials Office.

**CODES:** 1. Fully competent within defined scope of practice.

2. Supervision required. (Unlicensed/uncertified or lacks current relevant clinical experience.

3. Not approved due to lack of facility support. (Reference facility master Strawman. Use of this code is reserved for the Credentials Function.)

4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.

**CHANGES:** Any change to a verified/approved privileges list must be made in accordance with Service specific credentialing and privileging policy.

**NAME OF APPLICANT**

**NAME OF MEDICAL FACILITY**

I Scope		Requested	Verified
<b>P384471</b>	The scope of privileges for Chiropractors includes evaluation, diagnosis, and treatment of Active Duty patients, referred from other providers, with disorders of the musculoskeletal system. Chiropractic treatment includes the use of spinal manipulative therapy and/or other forms of manual therapy on articulations and/or muscular, tendonous and ligamentous soft tissues of the body, with emphasis on the spinal column. The chiropractor may use other supporting forms of treatment, such as physical modalities, decompression, and therapeutic exercise. Perform routine manual and mechanical, osseous and soft tissue chiropractic procedures for non-axial neurologic and musculoskeletal disorders or complaints.		
Diagnosis and Management (D&M)		Requested	Verified
<b>P384483</b>	Order orthotic devices, materials and appliances available through the MTF and commonly used in the chiropractic profession		
<b>P384485</b>	Provide instruction/recommendations regarding hygiene, nutrition, exercise, life style changes, stress reduction, and modifications of ergonomic factors as they relate to chiropractic treatment		
<b>P389664</b>	Order imaging studies in accordance with MTF policy		
<b>P389666</b>	Order diagnostic laboratory studies in accordance with MTF policy		
<b>P386000</b>	Initiate, continue, and terminate temporary/limited duty profile in accordance with Service policy		
<b>P389662</b>	Refer patients to other practitioners as appropriate		
<b>P386002</b>	Place patients on quarters in accordance with Service policy		
Procedures		Requested	Verified
<b>P384489</b>	Utilize the therapeutic modalities of heat, cold, light, electricity, ultrasound, traction and other procedures as appropriate in patient treatment		
Procedure Advanced Privileges (Requires Additional Training)		Requested	Verified
<b>P384487</b>	Utilize the therapeutic modality of laser		
Other (Facility- or provider-specific privileges only):		Requested	Verified
<b>SIGNATURE OF APPLICANT</b>		<b>DATE</b>	

**CLINICAL PRIVILEGES – CHIROPRACTIC (CONTINUED)**

**II CLINICAL SUPERVISOR'S RECOMMENDATION**

RECOMMEND APPROVAL

RECOMMEND APPROVAL WITH MODIFICATION  
(Specify below)

RECOMMEND DISAPPROVAL  
(Specify below)

**STATEMENT:**

**CLINICAL SUPERVISOR SIGNATURE**

**CLINICAL SUPERVISOR PRINTED NAME OR STAMP**

**DATE**