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, date 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, date 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**
P384471	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, tendinous 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**
P384483	Order orthotic devices, materials and appliances available through the MTF and commonly used in the chiropractic profession		
P384485	Provide instruction/recommendations regarding hygiene, nutrition, exercise, life style changes, stress reduction, and modifications of ergonomic factors as they relate to chiropractic treatment		
P389664	Order imaging studies in accordance with MTF policy		
P389666	Order diagnostic laboratory studies in accordance with MTF policy		
P386002	Place patients on quarters in accordance with Service policy		
P389662	Refer patients to other practitioners as appropriate		
P386000	Initiate, continue, and terminate temporary/limited duty profile in accordance with Service policy		
Procedures		**Requested**	**Verified**
P384489	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**
P384487	Utilize the therapeutic modality of laser		
Other (Facility or provider-specific privileges only):		**Requested**	**Verified**

SIGNATURE OF APPLICANT	**DATE**

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