

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 military service.

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, 3, 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, 3, 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 local facility privilege list. Use of this code is reserved for the Credentials Committee/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	
ADDRESS	

I Scope	Requested	Verified																												
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Other (Facility or provider-specific privileges only):	Requested	Verified																												

SIGNATURE OF APPLICANT		DATE
II CLINICAL SUPERVISOR'S RECOMMENDATION		
<input type="checkbox"/> RECOMMEND APPROVAL	<input type="checkbox"/> RECOMMEND APPROVAL WITH MODIFICATION	<input type="checkbox"/> RECOMMEND DISAPPROVAL
STATEMENT:		
CLINICAL SUPERVISOR SIGNATURE	CLINICAL SUPERVISOR PRINTED NAME OR STAMP	DATE