DHA Centralized Credentials Verification Service
200 Concord Plaza Drive, Ste 780
San Antonio, Texas 78216
(210) 812-2170
FAX: (210) 519-2724
E-mail: USAF.JBSA.AFMOA.MBX.AFCCVO@HEALTH.MIL

Recruiting application memo for Recruiters (AFRS, Reserve, ANG)

Hello Air Force recruiter! Please see the mock AF Form 1540 attached to this memo for an example of how the AF Form 1540 must be completed by your applicant. We want to emphasize, **all information on the AF Form 1540 is either entered into the provider's CCQAS record or assists in verifying their credentials as quickly as possible**. Please have your applicant type the AF Form 1540 as this makes corrections (if required) faster and easier and because **white out cannot be used on any AF Forms.**

The checklist you attach to the front of every application tells you exactly what we need. If you don't see it listed on that checklist, you don't need to submit it. On the rare occasion we need a copy of something, we'll ask. If you have a checklist that has you collecting copies of licenses, degrees, DEAs, etc. let us know and we'll send you an updated checklist.

Remember these things when submitting an application:

1. AF Forms, and privilege list(s) completed by applicants are valid for only **180 Days**.

2. Complete dates (mm/dd/yyyy) and addresses (street, city, state, zip) are required for **every address**, and **every date** on the 1540.

3. Every medical license (including training, temporary, inactive, expired), regardless of its current status, is to be listed on the 1540. Example: your MD applicant was an RN prior to receiving his MD. All RN licenses, and MD licenses, should be listed on the 1540.

4. Two AF Form 1562s are required, one from applicant's **CURRENT** clinical supervisor/medical director/chief and one from a **CURRENT** (same specialty) peer. The two individuals who complete the 1562s **must** be listed on page 2 of the AF Form 1540.

5. Although this won't delay processing of an application, all privileged providers are required to have an active BLS certification issued directly from either The American Heart Association or The American Red Cross. No exceptions.

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.
PRINCIPAL PURPOSE: To evaluate professional criteria for medical staff membership and clinical privileges; designed to help establish an applicant's background, current professional competence, and mental ability to discharge patient care responsibilities. This evaluation is essential to establishing and maintaining a qualified, competent staff.
ROUTINE USES: 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 performance of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges as a consultant to the Air Force.
DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

Exact date (mm/dd/yyyy) name was changed must be listed on page 4 (see pg 4)

APPLICANT COMPLETES SECTIONS I THROUGH X

I. IDENTIFICATION *(All date entries must be entered as MM/DD/YYYY)*

NAME *(Last, First, Middle Name)*	DATE OF BIRTH	GRADE	SSN	DATE
Doe, Jane, Ann (Smith, Poe)	01/31/1970	O-3	123-45-6789	01/01/2019
ALIAS *(i.e., Maiden)*				

HOME ADDRESS *(City, State, and Zip Code)*	HOME PHONE	DUTY PHONE	EMAIL ADDRESS
123 Home Street, San Antonio, TX 78216	210-210-2100	210-210-2101	jane.doe@umail.com

ORGANIZATION/OFFICE SYMBOL	DUTY SECTION	DAFSC	PAFSC	CORPS
				MC

SOURCE OF ACCESSION:

- ☐ Baccalaureate Degree Completion Program (BDCP)
- ☒ Direct Accession (DA)
- ☐ Enlisted Commissioning Program (ECP)
- ☐ Financial Assistance Program (FAP)
- ☐ Health Professional Scholarship Program (HPSP)
- ☐ Reserve Officer Training Corps (ROTC)
- ☐ Uniformed Services Univ. of Health Sciences (USUHS)
- ☐ National Guard
- ☐ Reserve
- ☐ Foreign National
- ☐ Civilian Civil Service
- ☐ Civilian Contractor
- ☐ Civilian Consultant
- ☐ Civilian Volunteer
- ☐ Other:

II. PROFESSIONAL EDUCATION *(Undergraduate/Graduate/Professional)*

NAME OF PROFESSIONAL SCHOOL	LOCATION	DATES ATTENDED FROM	DATES ATTENDED TO	DEGREE
The Best University	246 Pristine Street, Boston, MA 54321	01/01/1996	05/31/2000	MD

TIME GAP >30 DAYS. Explanation required on page 4 (see pg 4)

III. POST GRADUATE TRAINING *(Internship, Residency, Fellowship)*

NAME OF INSTITUTION	LOCATION	TYPE OF PROGRAM *(Residency, etc.)*	DATES ATTENDED FROM	DATES ATTENDED TO
Fantastic University	81012 Gross Street, Buffalo, NY 66666	Residency - Internal Medicine	07/01/2000	06/30/2006
Wonderful University	123 Fake Street, Boston, MA 30457	Fellowship - Rocket Surgery	07/01/2006	06/30/2007

IV. PRESENT AND PREVIOUS MILITARY AND CIVILIAN ASSIGNMENTS *(If additional space is nee*

TIME GAP >30 DAYS. Explanation required on page 4 (see pg 4)

NAME OF MEDICAL TREATMENT FACILITY (MTF) OR ORGANIZATION	LOCATION	SERVICE OR SP TO WHICH ASS	SIGNED FROM	SIGNED TO
St. Elsewhere	1988 Denzel Street, Boston, MA 30456	Internal Medicine	08/01/2006	05/01/2018
Jerry Jones General Hospital	1000 Texas Stadium Drive, Dallas, TX 75062	Internal Medicine	06/13/2018	Present

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

IV. PRESENT AND PREVIOUS MILITARY AND CIVILIAN ASSIGNMENTS *(Continued)* *(If additional space is needed, continue in Remarks, Page 4)*

NAME OF MEDICAL TREATMENT FACILITY (MTF) OR ORGANIZATION	LOCATION	SERVICE OR SPECIALTY TO WHICH ASSIGNED	DATES ASSIGNED FROM	DATES ASSIGNED TO

EVERY MEDICAL LICENSE EVER ISSUED must be listed (including training, temporary, inactive, expired, suspended etc.)

V. LICENSE/CERTIFICATION/REGISTRATION, SPECIALTY, AND FEDERAL DEA/STATE CSR *(If additional space is needed, continue in Remarks, Page 4)*

LICENSE/CERTIFICATION/REGISTRATION *(Must list **ALL** ever held.)*

STATE LICENSE *(Name of State)*	LICENSE NUMBER	DATE ISSUED	EXPIRATION DATE
Massachusetts	M64564265	01/02/2007	12/31/2022
Florida	564646	01/10/2000	01/10/2004
Texas	Q1450	06/01/2018	12/31/2021

NATIONAL CERTIFICATION	CERTIFICATE NUMBER	DATE ISSUED	EXPIRATION DATE

NATIONAL REGISTRATION	REGISTRATION NUMBER	DATE ISSUED	EXPIRATION DATE

Enter the name of the issuing authority here NOT the type of cert/reg issued (E.g. DO NOT ENTER 'Family Nurse Practitioner' enter 'American Academy of Nurse Practitioners')

SPECIALTY DATA

SPECIALTY *(List all specialties for which fully qualified)*: Internal Medicine, Rocket Surgery

BOARD CERTIFICATION *(Specialty Board)*	CERTIFICATE NUMBER	DATE ISSUED	EXPIRATION DATE
American Board of Internal Medicine	213133	07/01/2008	12/31/2019
American Board of Rocket Surgery	742542	09/05/2008	01/01/2020

FEDERAL DRUG ENFORCEMENT ADMINISTRATION (DEA)/STATE CONTROLLED SUBSTANCE REGISTRATION (CSR)

FEDERAL DEA *(Type)*	REGISTRATION NUMBER	DATE ISSUED	EXPIRATION DATE
DoD Fee-Exempt			
Federal (Fee-Paid)	ML1234567	05/17/2006	10/31/2021

STATE CSR *(Name of State)*	REGISTRATION NUMBER	DATE ISSUED	EXPIRATION DATE
Massachusetts	CSR.80002	01/02/2007	12/31/2022

VI. MEMBERSHIP IN PROFESSIONAL SOCIETIES *(If additional space is needed, continue in Remarks, Page 4)*

NAME OF SOCIETY	STATUS *(Member, Fellow, etc.)*
American Acadmey of Family Physicians	Member
Rocket Man Association	Member

References listed here must match the 2 references who completed AF Form 1562s. Note: the 1562s must be completed by CURRENT clinical supervisor/medical director/chief and CURRENT (same specialty) peer. CURRENT meaning from facility currently employed at.

VII. REFERENCES *(Every applicant MUST list*

NAME		
Dr. Tony Romo - Clinical Supervisor	1000 Texas Stadium Drive, Dallas, TX 75062	(512) 316 - 1234 tony.romo@jjgh.org
Dr. Dak Prescott - Peer	1000 Texas Stadium Drive, Dallas, TX 75062	(210) 111 - 1234 dak.prescott@jjgh.org
Dr. Jerry Jones - Medical Director	1000 Texas Stadium Drive, Dallas, TX 75062	(111) 111 - 1111 billionaire@jjgh.org

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

VIII. PRACTICE HISTORY *(Explain all "yes" responses in Remarks, Page 4)*

	YES	NO
A. Have there been previously successful or currently pending challenges, revocations, or restrictions to any license, certification, or registration (state, district or Drug Enforcement Administration) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such license, certification, or registration?	☐	☒
B. Have you ever had a voluntary or involuntary limitation, reduction, revocation, suspension, denial, or loss of clinical privileges?	☐	☒
C. Have you ever voluntarily or involuntarily terminated or been denied medical staff membership or membership in a professional group or society?	☐	☒
D. Have you ever been a defendant in a felony or a misdemeanor case? *(Indicate final disposition of case in Remarks, Page 4)*	☐	☒
E. Have you ever been a defendant or the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication, or any other resolved or unresolved allegations of inappropriate, unethical, unprofessional, or substandard care?	☐	☒
IF "YES" WAS THE RESPONSE:		
(1) Settled prior to final court action?	☐	☒
(2) Judgment rendered by the court?	☐	☒
(3) Defendant found liable?	☐	☒
(4) Matter still pending?	☐	☒

IX. HEALTH STATUS *(Explain all "yes" responses in Remarks, Page 4)*

See page 4

	YES	NO
A. Do you currently have any physical or mental impairment that could limit your clinical practice?	☐	☒
B. Are you currently taking any medications?	☒	☐
C. Do you have a potentially communicable disease?	☐	■
D. Have you ever been hospitalized for any reason in the past 5 years?	☐	☒
E. Have you ever been hospitalized for, or diagnosed with, a psychiatric disorder to include substance abuse?	☐	☒
F. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?	☐	☒
G. Have you ever used a controlled substance that was not prescribed for you by a physician or other health care provider?	☐	☒

X. STATEMENT OF APPLICANT *(PLEASE READ CAREFULLY BEFORE SIGNING)*

I certify all information submitted by me in this application is true to the best of my knowledge and belief and I have the ability to perform the clinical privileges requested.

I certify that any false or incomplete information knowingly provided on or with this application may be grounds either for not employing or accessing me or for dismissing or releasing me if I am already employed or serving. I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under United States Code Title 18, Section 1001.

I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I authorize all who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated healthcare organization, their staff, and agents. This includes individuals, institutions, and entities of organizations with which I am currently or have been associated, and all professional liability insurers with which I have had or curren professional liability insurance.

I consent to documents perti training, experie ability to perform if requested, ap

I agree to rel liability the United States and any and all persons who participate within the scope of their duties in good faith and without malice in the review of any action or recommendation relating to my application.

In making this application for clinical privileges, I acknowledge my responsibility to provide for the continuous care of my patients.

I have been informed that the medical staff bylaws, rules, and regulations *(AFI 44-119, Clinical Performance Improvement)* can be accessed at the following internet site: http://www.e-publishing.af.mil/ and agree that my activities as a medical staff member will be bound by these bylaws.

I acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and will cooperate in maintaining JCAHO standards.

I agree to subject my clinical performance to, and faithfully participate in, activities to measure, assess, nd improve performance on an organization-wide asis.

Most commonly marked answer here is 'yes' for medications. Medications currently being taken must be listed on page 4. All others require a *brief* explanation on page 4 and any court/legal documents available must be submitted

The only digital signature acceptable is from a CAC card

SIGNATURE OF APPLICANT	DATE
(An actual handwritten signature goes here, not a digital or typed one)	01/01/2019

APPLICATION FOR CLINICAL PRIVILEGES/MEDICAL STAFF APPOINTMENT *(Continued)*

FOR CREDENTIALS FUNCTION USE ONLY

TYPE OF CLINICAL PRIVILEGES

☐ Regular Privileges ☐ Supervised Privileges ☐ Temporary Privileges

TYPE OF MEDICAL STAFF APPOINTMENT

☐ Initial-Active Medical Staff Appointment ☐ Active Medical Staff Appointment ☐ No Medical Staff Appointment
☐ Initial-Affiliate Medical Staff Appointment ☐ Affiliate Medical Staff Appointment ☐ Temporary Medical Staff Appointment

XI. CLINICAL SUPERVISOR RECOMMENDATION

I have reviewed the provider's clinical privileges and confirm his/her physical and mental ability and qualifications to perform the requested privileges.

CLINICAL PRIVILEGES:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]
MEDICAL STAFF APPOINTMENT:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]

SIGNATURE OF CLINICAL SUPERVISOR *(USE NAME STAMP OR TYPE NAME AND TITLE)* **DATE**

XII. DEPARTMENT CHAIR / CHIEF OF SERVICE RECOMMENDATION

CLINICAL PRIVILEGES:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]
MEDICAL STAFF APPOINTMENT:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]

SIGNATURE OF DEPARTMENT CHAIR / CHIEF OF SERVICE *(USE NAME STAMP OR TYPE NAME AND TITLE)* **DATE**

XIII. CREDENTIALS FUNCTION CHAIRPERSON (SGH) RECOMMENDATION

CLINICAL PRIVILEGES:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]
MEDICAL STAFF APPOINTMENT:	☐ Approval	☐ Approval with Modification [1]	☐ Disapproval [1]

SIGNATURE OF CREDENTIALS FUNCTION CHAIRPERSON *(USE NAME STAMP OR TYPE NAME AND TITLE)* **DATE**

XIV. MEDICAL FACILITY COMMANDER APPROVAL

☐ Approved ☐ Approved with Modification [1] ☐ Disapproved [1]

SIGNATURE OF MEDICAL FACILITY COMMANDER *(USE NAME STAMP OR TYPE NAME AND TITLE)* **DATE**

REMARKS *(If additional space is needed, continue on plain bond paper)*:

Last name changed from Smith to Poe 01/01/1988
Last name changed from Poe to Doe 01/01/1990

Time gap from 05/31/2000 - 07/01/2000 - Awaited start of residency

Time gap from 05/01/2018 - 06/13/2018 - Relocated from Boston to Dallas, awaited Texas medical license to be issued

Section IX., B. - Duloxetine

(NOTE:1 Explain in "Remarks" on this page)