INSTRUCTIONS FOR
AIR FORCE FORM 1540
APPLICATION FOR CLINICAL PRIVILEGES / MEDICAL STAFF APPOINTMENT

For Use by Practitioners Completing Training

PURPOSE:

The form is to be submitted by practitioners completing education or training and being assigned to medical treatment facilities (MTF). The MTF will use it to establish a credential file and award clinical privileges.

Should you have questions regarding any sections in this form, please feel free to contact the AFCCVO by one of the following means:

- Mail: 1777 NE Loop 410, Ste 912, San Antonio, TX 78217
- Telephone: (210) 826-0242
- Fax: (210) 829-4526
- E-mail: udg_afmoa_afccvo@us.af.mil

SECTION I: IDENTIFICATION

Enter the following:

- Line 1: Name (Last, First, Middle), Date of Birth (MM/DD/YYYY), Grade (reflecting what is on your orders, which is what you will be when you graduate; e.g., O-3 for Captain), Social Security Number, and Date.

- Line 2: Home Address (City, State, Zip Code), Home Phone number, Duty (work) Phone number, and Email Address.

- Line 3: The Organization/Office Symbol is where you are going to be assigned; e.g., the Cardiology Department in the Surgical Operations Squadron at Wilford Hall Medical Center is 759 MSGS/MCCC.

- Line 3: Leave the Duty Section blank.

- Line 3: DAFSC means “Duty Air Force Specialty Code” and PAFSC means “Primary Air Force Specialty Code,” which can be found on your orders. These are alphanumeric codes used to identify job groups. All AF Medical Service officer codes start with a 4. For example, the AFSC for a qualified Family Physician is 44G3.

- Line 3: The choices for Corps are MC (Medical Corps) for physicians, DC (Dental Corps) for dentists, BSC (Biomedical Sciences Corps) for allied health professionals, and NC (Nurse Corps) for nurses.

- Line 4: Check the source of accession that applies to you.

SECTION II: PROFESSIONAL EDUCATION

List all information regarding your professional schools (MD, DO, PhD., etc.) as indicated.

- Be sure to list all dates in MM/DD/YYYY format.

- You do not need to include undergraduate education if it does not relate to your abilities as a privileged provider.

SECTION III: POST GRADUATE EDUCATION

List all parent hospitals/institutions at which you received postgraduate training. You should only list the organization granting a certificate of completion. **Do not** list facilities where you only performed clinical rotations.

- Be sure to list all dates in MM/DD/YYYY format.

SECTION IV: PRESENT AND PREVIOUS MILITARY AND CIVILIAN ASSIGNMENTS

List organizations where you have worked since completion of professional school. Do not include periods of residency/fellowship training in this section (If applicable).

- Be sure to list all dates in MM/DD/YYYY format.

- All time gaps of more than 30 days **must** be explained in the remarks section.

SECTION V: LICENSE/CERTIFICATION/REGISTRATION, SPECIALTY, AND FEDERAL DEA/STATE CSR

List all licenses and/or other authorizing documents to practice (e.g., national certifications, registrations, if applicable) and narcotics registration(s) (i.e., DEA, State CSR) you currently hold, both active and inactive. In addition, you must provide an explanation of any licenses and narcotics registrations that are not current, have been involuntarily relinquished, or have been subjected to disciplinary action, voluntary or involuntary limitation, suspension, or revocation.

List specialty or specialties in which you are fully qualified (completed residency/fellowship training), including the following:

- Specialty/specialties in which you are board eligible (will take certification examination the next time offered).

- Any information regarding completion of specialty board certification.

SECTION VI: MEMBERSHIP IN PROFESSIONAL SOCIETIES

List any professional societies (AMA, ACOG, etc.) in which you are a member, and include your status (Member, Fellow, etc.).

SECTION VII: REFERENCES

List three professional references, including the requested contact information. ***NOTE:*** **One reference must be your program director/dean; the other two must be from instructors, preceptors or senior staff providers who know your work well.**

SECTIONS VIII/IX: PRACTICE HISTORY/HEALTH STATUS

Answer all questions in subsections; all "yes" responses require explanation (use Remarks section on page 4).

SECTION X: STATEMENT OF APPLICANT

Read the statement carefully and then **sign and date form**.