DELINEATION OF CLINICAL PRIVILEGES - INTERNAL MEDICINE

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Category I.
Uncomplicated illnesses or problems that have low risk to the patient. Non-specialists with little or no residency training but with reasonable experience in the care of these conditions.

Requested	Approved	
		Category I clinical privileges

Category II. Includes Category I.
Major illnesses, injuries, conditions or procedures, but with no significant risk to life. Significant graduate training in the specialty related to the conditions, or considerable experience in the care of the conditions is appropriate.

Requested	Approved	
		Category II clinical privileges

Category III. Includes Categories I and II.
Major illnesses, conditions, or procedures that carry substantial threat to life. Board certification or other extensive training and experience in the care of these conditions is required.

Requested	Approved	
		Category III clinical privileges

Category IV. Includes Categories I, II, and III.
Unusually complex or critical diagnoses or treatment with serious threat to life. Extensive relevant subspecialty training or experience beyond board certification is typical.

Requested	Approved	
		Category IV clinical privileges

Medical Subspecialty. Initial the subspecialty(ies) for which clinical privileges are being requested.
NOTE: If a separate privilege list for the subspecialty is in use, please attach this document.

Requested	Approved		Requested	Approved	
		Allergy/Immunology			Internal Medicine
		Cardiology			Critical Care
		Endocrine and Metabolic Disease			Nephrology
		Gastroenterology			Pulmonary Disease
		Hematology/Oncology			Rheumatology
		Infectious Disease			

GENERAL INTERNAL MEDICINE PROCEDURES

Requested	Approved		Requested	Approved	
		a. Arterial puncture			i. Endotracheal intubation
		b. Arthrocentesis			j. Flexible sigmoidoscopy and biopsy
		c. Bone marrow aspiration and biopsy			k. Fluoroscopy
		d. Central venous cannulation			l. Paracentesis
		e. Chest tube insertion			m. Pericardiocentesis (emergent)
		f. Moderate sedation			n. Pulmonary function interpretation
		g. Electrocardiogram (ECG) interpretation			o. Skin biopsy
		h. Electrocardioversion			p. Spinal tap

GENERAL INTERNAL MEDICINE PROCEDURES *(Continued)*					
Requested	Approved		Requested	Approved	
		q. Thoracentesis			
		r. Treadmill stress tests *(Thallium, etc.)*			

ADDITIONAL GASTROENTEROLOGY PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Colonoscopy - diagnostic and therapeutic			h. Esophagogastroduodenoscopy - therapeutic
		b. Diagnostic ERCP			i. Liver biopsy
		c. Therapeutic ERCP			j. Percutaneous endoscopic gastrostomy
		d. Esophageal dilation			
		e. Esophageal manometry			
		f. 24-hour pH study			
		g. Esophagogastroduodenoscopy - diagnostic			

ADDITIONAL CARDIOLOGY PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Cardiac catheterization			d. Transthoracic echocardiography
		b. Intraaortic balloon pump insertion			
		c. Transesophageal echocardiography			

ADDITIONAL HEMATOLOGY/ONCOLOGY PROCEDURES	
Requested	Approved
	a. Cisternal tap
	b. Prescription and administration of chemotherapy and biological therapy by IV, SQ, IM, IT, and intracavitary routes
	c. High dose chemotherapy with stem cell rescue, autologous and allogeneic

ADDITIONAL PULMONARY PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Bronchoscopy *(Biopsy, brushing, and lavage)*			c. Pleural biopsy
		b. Lung biopsy			

ADDITIONAL ALLERGY PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Rhinoscopy			

ADDITIONAL ICU PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Arterial cannulation			d. Ventilator management
		b. Pulmonary artery catheterization			
		c. Transvenous temporary pacing			

ADDITIONAL ENDOCRINOLOGY PROCEDURES					
Requested	Approved		Requested	Approved	
		a. Thyroid biopsy			

OTHER PROCEDURES *(Specify Subspecialty)*					
Requested	Approved		Requested	Approved	

COMMENTS

COMMENTS *(Continued)*		
	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS		
DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS		
COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*