EVALUATION OF CLINICAL PRIVILEGES - CRITICAL CARE 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. PERIOD OF EVALUATION (YYYYMMDD)						
		FROM	TO					
4. DEPARTMENT/SERVICE	5. FACILITY (Name and Address: City/State/ZIP Code)							

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, <u>line through and initial</u> any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

CODE	PRIVILEGE CATEGORY	ACCEPTABLE	UN- ACCEPTABLE	NOT APPLICAB
	a. Pediatric intensive care disorders	ACCEPTABLE	ACCEPTABLE	AFFLICAE
	b. Treatment of respiratory failure			
	c. Thoracentesis			
	d. Paracentesis			
	e. Pericardiocentesis			
	f. Arthrocentesis			
	g. Tube thoracostomy			
	h. Flexible tube broncoscopy			
	i. Transtracheal needle aspiration			
	j. Intubation - Oral and nasotracheal			
	k. Percutaneous tracheostomy			
	I. Ventilator management to include rapid frequency			
	m. Central venous line placement			
	n. Swan-Ganz catheterization			
	o. Arterial line placement			
	p. Venous cutdown			
	q. Intracranial pressure monitoring			
	r. Lumbar cerebrospinal fluid examination			
	s. Percutaneous placement of peritoneal dialysis catheter			
	t. Peritoneal lavage and dialysis			
	u. Continuous hemofiltration dialysis			
	v. Cardioversion including defibrillation			
	w. Transvenous pacemaker insertion			
	x. Balloon tamponade of bleeding esophageal and gastric varices			
	y. Administration of moderate sedation			
	z. Supervision and application of respiratory therapy; gas humidification; positive			
	pressure ventilation; postural drainage and percussion  aa. Other (Specify)			
	an other (speen)			
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SECTION II - COMM	ENTS (Explain any rating that is "Unacceptable".)	
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NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE (YYYYMMDD)