

**NAVY MEDICINE SUPPORT COMMAND
CENTRALIZED CREDENTIALS AND PRIVILEGING DEPARTMENT
BOX 140 CCPD
JACKSONVILLE, FLORIDA 32212-0140**

**PERSONAL AND PROFESSIONAL INFORMATION SHEET
PRIVILEGED PROVIDER**

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to the practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff providers' competence.

ROUTINE USE: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

DISCLOSURE IS MANDATORY: Failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. Please make any corrections or additions to the information below in pen and ink. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon.)

1. Name: _____ **SSN:** _____
Maiden/Alias (Last, First, MI)

Specialty: _____ (MD, DDS, FNP, etc.)

Date of Birth (MM/DD/YYYY): _____ **NPI:** _____

Home Address: _____

Home Phone: () _____ Fax: () _____

Cell Phone: () _____ Pager: () _____

Work address: _____

Work Phone: () _____ Work Fax: () _____

Email Address(s): _____ Primary Email: _____

Note: (Please indicate which is the best method to be contacted.) _____

2. PROFESSIONAL EDUCATION AND TRAINING (list most recent first):

a. Basic Qualifying Degree (i.e. MD, DO, OD, MSW, MSN, etc.)

Institution (Name and Location)	Degree	From	To
_____	_____	_____	_____
_____	_____	_____	_____

Name: _____ SSN: _____

b. Internship (INT), Residency (RES), Fellowship (FEL), additional Degrees

Institution (Name and Location)	Specialty Type	From	To
_____	_____	_____	_____
_____	_____	_____	_____

3. BOARD CERTIFICATIONS

a.	Are you Board eligible (Y/N): _____	Are you Board certified	(Y/N): _____
b.	Certification or Re-certification	Issue Date	Expiration Date
	_____	_____	_____
	_____	_____	_____

4. LICENSURE OR CERTIFICATION BY STATE OR FEDERAL AGENCY:

a. License Information

License #	State	Status: (Active/Expired)	Expires
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. Certification Information

Certificate #	Cert	Status	Expires
_____	_____	_____	_____
_____	_____	_____	_____

c. Drug Enforcement Agency/Controlled Dangerous Substance Number(s)

DEA/CDS(State) #	Type	Expires
_____	_____	_____
_____	_____	_____

5. MEDICAL READINESS TRAINING (indicate trained "T" or instructor "I"):

Training	"T"/"I"	Expiration Date
BLS	_____	_____
ACLS	_____	_____
ATLS	_____	_____
NRP	_____	_____

I hereby attest that I understand the requirement that I be certified in a CPR course provided by the American Heart Association/HEALTHCARE PROVIDER or the American Red Cross/PROFESSIONAL RESCUER while I am in the Navy per BUMEDINST 1500.15. I understand that I am responsible for providing documentation of my certificate upon request.

Signature: _____ Date: _____

Name: _____ SSN: _____

6. HEALTH STATUS AND ABILITY TO PERFORM: (ANSWER Yes or No)

(Note: Explain all Yes answers (except 6.a) in comments Section.)

- ___ a. Have you met the Navy's requirement to have a completed annual physical examination, either long or short form, within the past 12 months? (If not, please explain.)
- ___ b. Do you currently have any physical or mental impairments that could limit your clinical performance?
- ___ c. Are you currently taking any medications?
- ___ d. Do you have a potentially-communicable disease?
- ___ e. Have you been hospitalized for any reason during the last 5 years?
- ___ f. Have you ever been psychiatrically hospitalized or diagnosed with a major psychiatric disorder?
- ___ g. Are you currently under or have you ever received treatment for an alcohol or drug related condition?
- ___ h. Have you ever been arrested or detained for an alcohol or drug-related incident?
- ___ i. Have you ever been involved in the unlawful use of controlled substances?

Comments:

7. MALPRACTICE, LICENSURE, AND LEGAL HISTORY: (Yes or No)

(Note: Explain ALL YES answers in Comments Sections.)

- ___ a. Have you ever been denied a staff appointment or had your privileges suspended, limited, revoked, or had a renewal/appointment denied?
- ___ b. Have you ever been the subject of a malpractice claim?
(Indicate final disposition or current status of claim in comments.)
- ___ c. Have you ever been the subject of investigation resulting in the termination of employment or a contractual arrangement?
- ___ d. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)
- ___ e. Have you ever voluntarily resigned or otherwise disassociated yourself from employment or practice after being notified of intent to start action against you for failure to properly accomplish your professional responsibilities?
- ___ f. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated your staff appointment (membership)?
- ___ g. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated, or lost your clinical privileges?
- ___ h. Have there been previously successful or currently pending challenges, investigations, revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial or withdrawal to any licensure, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?
- ___ i. Are you now or have you ever been required to appear before any medical or state regulatory authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?
- ___ j. Has there ever been any resolved or open charges of misconduct, unethical practice, or substandard care?

Comments:

Name: _____ SSN: _____

8. PROFESSIONAL LIABILITY

a. Are you employed by a healthcare facility or agency and covered under their professional liability insurance? **YES** _____ **NO** _____ (If **no** please answer questions (1) through (5) below.)

- (1) CARRIER NAME/PHONE NUMBER: _____
- (2) CARRIER ADDRESS: _____
- (3) POLICY NUMBER: _____
- (4) AMOUNT OF COVERAGE: _____
- (5) DATES OF COVERAGE: _____

9. OTHER INFORMATION (Include any additional information that you wish to bring to the attention of CCPD.)

10. CONTINUING EDUCATION HOURS

a. Have you fulfilled the state licensure requirements for continuing education? **YES** _____ **NO** _____ (If not, please explain.)

b. Have you participated in continuing education in each requested area of specialization during the past 2 years? (i.e., Flight Surgery, Internal Medicine) **YES** _____ **NO** _____ (If not, please explain.)

Comments:

11. DEPARTMENT DIRECTOR/CHIEF OF SERVICE REFERENCE:

Name _____ Work Phone (____) _____
FAX (____) _____ Full Address _____

12. PEER REFERENCES: Please provide two peer references (**same specialty**, i.e. Clinical Dietician/Clinical Dietician, Internal Med/Internal Med, General Dentist/General Dentist, Family Nurse Practitioner/Family Nurse Practitioner) who can attest to your qualifications in core specialty **based on current clinical experience within the past two years.**

Name _____ Work Phone (____) _____ FAX (____) _____
Full Address _____

Name _____ Work Phone (____) _____ FAX (____) _____
Full Address _____

Name: _____ SSN: _____

13. PROFESSIONAL ASSIGNMENTS: Please provide all information requested for each place (Civilian/ Military/ Private Practice) you have been employed/held privileges since completing your respective training program (i.e. Medical School, PA Program, FNP Program, etc). Indicate if direct patient care was involved. If yes, **was it in your current specialty?** List in chronological order with the most recent first, and identify all gaps in employment history.

Facility/Institution _____ PHONE(____) _____ FAX(____) _____

Address: _____

Direct Patient Care (Y/N): _____ If yes, how many hours per week? _____

Privileges held (Y/N) _____ Position/Specialty _____
Point of Contact: _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE(____) _____ FAX(____) _____

Address: _____

Direct Patient Care (Y/N) _____ If yes, how many hours per week? _____

Privileges held (Y/N) _____ Position/Specialty _____

Point of Contact: _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE(____) _____ FAX(____) _____

Address _____

Direct Patient Care (Y/N) _____ If yes, how many hours per week? _____

Privileges held (Y/N) _____ Position/Specialty _____

Point of Contact: _____

Contact: _____

Dates of Affiliation From: _____ To: _____

Name: _____ SSN: _____

Facility/Institution _____ PHONE() _____ FAX() _____
Address _____

Direct Patient Care If yes, how many hours per week? _____
(Y/N) _____

Privileges held Position/Specialty _____
(Y/N) _____

Point of Contact: _____

Dates of Affiliation From: _____ To: _____

Facility/Institution _____ PHONE() _____ FAX() _____
Address _____

Direct Patient Care If yes, how many hours per week? _____
(Y/N) _____

Privileges held Position/Specialty _____
(Y/N) _____

Point of Contact: _____

Dates of Affiliation From: _____ To: _____

**** If currently working in a non-clinical setting, or working less than 10 clinical hours a week, briefly describe your current occupation and job activities**:**

I affirm and attest that the information I will keep my file current by informing the Navy Medicine Support Command, Jacksonville, Florida of any changes, including but not limited to: my demographic information, my state license(s)/certification(s), any change in my medical staff/employment status at any facility, any change in my professional liability insurance coverage, or the filing of a lawsuit against me.

Signature: _____ Date: _____

INDIVIDUAL CREDENTIALS/PROFESSIONAL FILE

CONSENT AND RELEASE/PRIVACY ACT STATEMENT

Name: _____ **SSN:** _____

As a Direct Commission Officer Candidate to the U.S. Navy , I hereby make the following authorizations:

- REFERENCES: Authorize the Navy Medicine Support Command, Jacksonville, Florida, and its representatives to consult with my current and prior associates and others who may have information regarding my clinical competence and other qualifications and to verify information in my file;
- INSPECTION OF RECORDS: Consent to the inspection by the Navy Medicine Support Command, Jacksonville, Florida, and its representatives, of all records and documents, that would evaluate my competence and professional, moral, and ethical qualifications;
- LIABILITY INSURANCE: Authorize release of information from current and prior liability insurance carrier(s) regarding any and all information related to coverage and claim history under their company(ies);
- RELEASE FROM LIABILITY: Release from liability any and all individuals and organizations who provide information to the Navy Medicine Support Command, Jacksonville, Florida, and its representatives, in good faith and without malice concerning my clinical competence, ethics, moral character and any other qualifications. (Peer review activities are protected under the Health Care Quality Improvement Act of 1986 (HCQIA).
- TIME FRAME FOR AUTHORIZATION: This form serves as authorization for securing information for two years from the date signed.

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Title 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
2. **PURPOSE:** To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials and privileging function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.
3. **ROUTINE USE:** Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
4. **DISCLOSURE IS MANDATORY:** In the case of all personnel, the requested information is mandatory because of the need to document all credentialing and quality assurance (performance improvement) data. If the requested information is not furnished, further action on your ICF/IPF will not be possible. This all inclusive privacy act statement will apply to all requests for personal information made by personnel for credentials review purposes and will become a permanent part of your ICF/IPF.

Your signature acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF MEMBER

SSN OF MEMBER

DATE

THE CENTRALIZED CREDENTIALS AND PRIVILEGING DEPARTMENT

A Department of the Navy Medicine Support Command, Jacksonville, Florida

Professional Peer Inquiry

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

PURPOSE: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

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DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

Provider's Name: _____

Provider's Specialty: _____

The above named provider is undergoing the credentials review process within the Department of the Navy. We request your conscientious appraisal of the individual's ability to provide quality health care. Please base your evaluation on the provider's demonstrated performance over the past two years, compared to that reasonably expected of a provider with a similar level of training, experience and background. An authorization for release of information signed by the provider and a return envelope are enclosed. If this is faxed to you, please fax this completed inquiry back to CCPD at (904) 542-6727 promptly. Thank you for your assistance.

PERSONAL INFORMATION

- 1. Have you worked with the provider within the past two years? _____
- 2. How long have you known the provider? _____
- 3. What is your relationship with the provider? _____

EVALUATION

If you answer "NO" to questions 1-11 below, please provide an explanation on separate attached sheet

"Check or mark "YES" for "meets community standards". Check or mark "No" for "does not meet community standards". Check or mark "UNK" for "unknown".

	YES	NO	UNK
1. Professional Knowledge	_____	_____	_____
2. Practitioner/Patient Relationship	_____	_____	_____
3. Professional Judgment	_____	_____	_____
4. Practitioner-Staff Relationship	_____	_____	_____
5. Clinical Competence	_____	_____	_____
6. Practitioner-Peer Relationship	_____	_____	_____
7. Technical Skill	_____	_____	_____
8. Patient Care	_____	_____	_____
9. Ethical Conduct	_____	_____	_____
10. Quality and completion of health records	_____	_____	_____
11. Participation in medical affairs	_____	_____	_____

Provider's Name: _____ SSN: _____
Provider's Specialty: _____

If you answer "YES" to questions 1-5 below, please provide an explanation on separate attached sheet.

1. Have significant **negative** trends in the provider's clinical performance been identified? **YES NO**

2. To your knowledge has the provider been investigated or had any disciplinary action taken (i.e. License, suspension, limitation, revocation)? **YES NO**

3. To your knowledge has the provider ever been under investigation by any governmental or other legal body? **YES NO**

4. Does the provider have a physical or mental condition, which could affect his/her ability to perform professional skills or would require an accommodation in order to perform professional skills safely and competently? **YES NO**

5. Is there anything that you like to discuss with us over the phone? If yes, please call (877)772-4373, ext: 5116 or ext: 5142. **YES NO**

GENERAL IMPRESSION

My general impression of the provider is _____

RECOMMENDATION

- _____ **Recommend without reservation**
- _____ **Recommend with reservation** (Explain on separate sheet)
- _____ **Do not recommend** (Explain on separate sheet)

Institution _____

Phone number: _____

Printed name _____

Position _____ Specialty _____

Signature _____ Date _____

Email: _____

THE CENTRALIZED CREDENTIALS AND PRIVILEGING DEPARTMENT

A Department of the Navy Medicine Support Command, Jacksonville, Florida

Professional Peer Inquiry

PRIVACY ACT STATEMENT

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Provider's Name: _____ **SSN:** _____

Provider's Specialty: _____

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PERSONAL INFORMATION

- 1. Have you worked with the provider within the past two years? _____
- 2. How long have you known the provider? _____
- 3. What is your relationship with the provider? _____

EVALUATION

If you answer "NO" to questions 1-11 below, please provide an explanation on separate attached sheet

"Check or mark "YES" for "meets community standards". Check or mark "No" for "does not meet community standards". Check or mark "UNK" for "unknown".

	YES	NO	UNK
1. Professional Knowledge	_____	_____	_____
2. Practitioner/Patient Relationship	_____	_____	_____
3. Professional Judgment	_____	_____	_____
4. Practitioner-Staff Relationship	_____	_____	_____
5. Clinical Competence	_____	_____	_____
6. Practitioner-Peer Relationship	_____	_____	_____
7. Technical Skill	_____	_____	_____
8. Patient Care	_____	_____	_____
9. Ethical Conduct	_____	_____	_____
10. Quality and completion of health records	_____	_____	_____
11. Participation in medical affairs	_____	_____	_____

Provider's Name: _____ SSN: _____
Provider's Specialty: _____

If you answer "YES" to questions 1-5 below, please provide an explanation on separate attached sheet.

- 1. Have significant **negative** trends in the provider's clinical performance been identified? YES NO
- 2. To your knowledge has the provider been investigated or had any disciplinary action taken (i.e. License, suspension, limitation, revocation)? YES NO
- 3. To your knowledge has the provider ever been under investigation by any governmental or other legal body? YES NO
- 4. Does the provider have a physical or mental condition, which could affect his/her ability to perform professional skills or would require an accommodation in order to perform professional skills safely and competently? YES NO
- 5. Is there anything that you like to discuss with us over the phone? If yes, please call (877)772-4373, x5114 or 5142. YES NO

GENERAL IMPRESSION

My general impression of the provider is _____

RECOMMENDATION

- _____ **Recommend without reservation**
- _____ **Recommend with reservation** (Explain on separate sheet)
- _____ **Do not recommend** (Explain on separate sheet)

Institution _____

Phone number: _____

Printed name _____

Position _____ Specialty _____

Signature _____ Date _____

Email: _____

THE CENTRALIZED CREDENTIALS PRIVILEGING DEPARTMENT

A department of the Navy Medicine Support Command, Jacksonville, Florida

Civilian Employment Credential/Privileging Inquiry

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

PURPOSE: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

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DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

Provider's Name: _____ **SSN:** _____

Provider's Specialty: _____

The above named provider is undergoing the credentials review process within the Department of the Navy. We request your conscientious appraisal of the individual's ability to provide quality health care. Please base your evaluation on the provider's demonstrated performance over the past two years, compared to that reasonably expected of a provider with a similar level of training, experience and background. An authorization for release of information signed by the provider and a return envelope are enclosed. If this is faxed to you, please fax this completed inquiry back to CCPD at (904) 542-6727 promptly. Thank you for your assistance.

***IF A QUESTION DOES NOT PERTAIN TO YOUR PARTICULAR EMPLOYEE, PLEASE ANSWER N/A OR UNKNOWN IN SPACE PROVIDED.**

SCOPE OF CARE

1. Privileges/Job title that the provider/employee holds at your facility: _____

2. Dates of employment: From: _____ To: _____

3. Provider/employee data for **last 2 years at your facility**

(a) # of admissions or outpatient encounters _____/_____

(b) # of days unavailable (i.e. conferences, illness, vacation) _____/_____

(c) # of major procedures or encounters _____/_____

*MAJOR PROCEDURES MAY VARY ACCORDING TO PROFESSION/SPECIALTY. QUESTION MAY BE ANSWERED "N/A".

Provider's Name: _____ **SSN:** _____
Provider's Specialty: _____

HEALTH STATUS INQUIRY (circle appropriate mark)

Does the provider have a physical or mental condition, which could affect his/her ability to perform professional skills or would require an accommodation in order to perform professional skills safely and competently? **YES NO**

ADVERSE ACTIONS OR TRENDS (circle appropriate mark)

If you answer "YES" to questions a-f below (as they pertain to your facility) please provide full details on separate attached sheet. Has the applicant:

- a. Had privileges adversely denied, suspended, limited or revoked? **YES NO**
- b. Had privileges non-adversely reduced? **YES NO**
- c. Required counseling, additional training, or special supervision? **YES NO**
- d. Failed to obtain appropriate consultation? **YES NO**
- e. Had significant negative trends in clinical performance? **YES NO**
- f. Been under investigation by any governmental or other legal body? **YES NO**

SUMMARY RECOMMENDATION

1. WOULD YOU RECOMMEND THE PROVIDER? (CIRCLE ONE A, B, or C below)

- a. WITHOUT RESERVATION
- b. WITH RESERVATION
- c. NOT RECOMMEND

If desired, provide on a separate piece of paper your evaluation of this practitioner's clinical competency, as you have observed, and any other comments that will assist in our inquiry. We thank you for your objective response to these questions. For questions or comments about this inquiry, you may call our office at (877) 772-4373 x: 5114 or x: 5142.

Institution _____

Phone number: _____

Printed name _____

Position _____ Specialty _____

Signature _____ Date _____

Email: _____