DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH VA 22042

BUMEDINST 6010.17D
BUMED-N10G
24 Apr 2025

BUMED INSTRUCTION 6010.17D

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICAL STAFF BYLAWS

Ref: (a) OPNAVINST 5450.215F
(b) DoD Instruction 6025.13 of 26 July 2023
(c) BUMEDINST 6010.30
(d) DHA-PM 6025.13, Volume 3, Procedures Manual, Clinical Quality Management in the Military Health System: Healthcare Risk Management, 29 August 2019
(e) DHA-PM 6025.13, Volume 4, Procedures Manual, Clinical Quality Management in the Military Health System: Credentialing and Priviliging, 29 August 2019
(f) SECNAVINST 1920.6D
(g) SECNAVINST 12752.1A
(h) OPNAVINST 6320.7B/MCO 6320.4A

Encl: (1) Navy Medical Staff Bylaws Template

1. Purpose. Establishes Bureau of Medicine and Surgery (BUMED) policy, assigns responsibility, and serves as the formal organizational structure for privileging authorities, medical executive committees (MEC), and licensed independent providers granted privileges to practice within Navy Medicine operational clinical healthcare services, regardless of platform type or installation. Medical staff bylaws define command-specific responsibilities and outlines general obligations and rights of medical staff members. Enclosure (1) provides a template for command-specific medical staff bylaws. This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6010.17C.

3. Scope and Applicability. This instruction applies to Navy and Marine Corps operational clinical healthcare services, regardless of platform type or installation. It is applicable to all privileged, non-privileged, and unlicensed staff (e.g., hospital corpsman and independent duty corpsman (IDC)) who work under a scope of practice or are supervised (directly or indirectly) by a licensed healthcare provider.

4. Background. The Secretary of the Navy (SECNAV) has policy oversight of the Clinical Quality Management program within the Department of the Navy (DON). The Surgeon General of the Navy serves as the Chief, BUMED, and the principal advisor to SECNAV on all health

and medical matters of the Navy and Marine Corps including policy development relating to such matters, per reference (a). The Chief of Naval Operations and Commandant of the Marine Corps are committed to continuously improving the quality of medical and dental care provided to all DON personnel regardless of assignment.

5. Policy. All healthcare professionals providing medical care within DON are subject to credentialing and privileging requirements, per references (b), (c), (d) and (e). For the purposes of this document, medical staff is defined as privileged providers and includes all physicians, dentists, advanced practice registered nurses, and allied health providers who are eligible for independent clinical privileges, as defined in references (b) and (c).

6. Roles and Responsibilities

a. The Surgeon General of the Navy is the SECNAV-designee, DON Corporate Privileging Authority, to include governing body responsibilities. Governance is the ultimate authority and responsibility for technical professional evaluation and execution of the Credentialing and Privileging Program across Navy Medicine in the operational environment.

(1) Designates the privileging authorities with authority to further delegate privileging authority within their area of responsibility, in accordance with reference (c).

(2) Holds the authority to take adverse privileging action at the level at which the provider's privileges were approved and may not be further delegated.

b. Designated privileging authorities serve as representatives of the governing body of BUMED, and are ultimately responsible for the delivery of high-quality patient care delivered under their privileging authority. Privileging authorities will:

(1) Credential and privilege all licensed providers who are eligible for independent clinical privileges as defined in references (c), (d), and (e).

(2) Issue interfacility credential transfer briefs to providers seeking privileges at a medical treatment facility for sustainment of medical competencies and at other units as required.

(3) Establish medical staff bylaws to ensure compliance with references (a) through (h).

(4) Provide access to the medical staff bylaws.

(5) Ensure compliance with the medical staff bylaws.

c. The MEC has primary authority for activities related to governance of the organized medical staff and performance improvement of professional services provided by licensed

independent practitioners. All members of the medical staff are eligible for appointment or election to the MEC. Any medical staff member who holds clinical privileges and is actively practicing is considered eligible. MEC responsibilities include:

(1) Developing medical staff bylaws to comply with references (a) through (h).

(2) Ensuring compliance with the medical staff bylaws for providers under their privileging authority.

d. Licensed providers who are eligible for independent clinical privileges, as defined in references (c), (d), and (e), are subject to credentialing and privileging requirements as set forth in reference (c), and all local command developed medical staff bylaws, rules and regulations, and policies and procedures. Failure to abide by any of the responsibilities listed may result in processing for separation for cause under reference (f) for military personnel or administrative, or disciplinary action including termination of employment under reference (g), for civilian personnel.

e. Unlicensed providers, as defined in references (b), (c), (d), (e), and (h), are subject to credentialing requirements as forth in reference (c) and all local command developed medical staff bylaws, rules and regulations, and policies and procedures. Failure to abide by any of the responsibilities listed may result in processing for separation for cause, per reference (f), for military personnel or administrative, or disciplinary action, per reference (g), for civilian personnel.

7. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the DON Assistant for Administration, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-InformationManagement/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the OPNAV Records Management Program (DNS-16).

8. Review and Effective Date. Per OPNAVINST 5215.17A, Clinical Operations, Policy and Standards (BUMED-N10) will review this instruction annually around the anniversary of the issuance date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it

meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

9. Information Management Control. Reports required in enclosure 1, paragraphs 3 and 11 of this instruction are exempt from reports control per Secretary of the Navy Manual 5214.1 of December 2005, part IV, subparagraph 7k.

D. K. VIA

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, https://www.med.navy.mil/Directives/

NAVY MEDICAL STAFF BYLAWS TEMPLATE

1. Purpose. To serve as bylaws for licensed independent providers granted privilege to practice at _____ and to assist the privileging authority and organized medical staff to maintain compliance with Department of Defense (DoD), Defense Health Agency (DHA), and Bureau of Medicine and Surgery (BUMED) directives. For the purposes of this document, medical staff is defined as privileged providers and includes all physicians, dentists, advanced practice registered nurses, and allied health providers who are eligible for independent clinical privileges, as defined in BUMEDINST 6010.30 and DHA-PM 6025.13, Volume 4.

2. Applicability. These bylaws apply to all privileged providers, as defined in BUMEDINST 6010.30 and DoD Instruction 6025.13, assigned to _____. All healthcare professionals providing medical care within Department of the Navy (DON) are subject to credentialing and privileging requirements, per BUMEDINST 6010.30. Applicants for appointment to the medical staff must be familiar with the bylaws and agree in writing to abide by them.

3. Organization Structure and Roles and Responsibilities

a. Governing Body. Per BUMEDINST 6010.30, the Surgeon General of the Navy fulfills the governing body responsibilities and is responsible for technical professional evaluation and execution of the Credentialing and Privileging Program. Privileging authorities, as designated in BUMEDINST 6010.30, serve as representatives of the governing body of BUMED, and as such are ultimately responsible for the delivery of high-quality patient care under their privileging authority. Privileging authorities will ensure the medical staff develop local command medical staff bylaws, are provided access to the medical staff bylaws, and comply with the bylaws. The designated privileging authority for _____ is _____.

b. Medical Executive Committees (MEC). The privileging authority will appoint the MEC Chair and co-chair with medical staff input via a nominative process. [If applicable, a brief description of the command's nominative process can be inserted here].

(1) The MEC Chair will be a senior member of the medical staff.

(2) All members of the medical staff are eligible for appointment or election to the MEC. A medical staff member actively practicing cannot be considered ineligible based solely on the professional specialty or discipline. [If applicable, description of the command's specific information about the MEC, including its function, size, composition, scope of responsibilities, and delegated authority can be inserted here.]

(a) MEC Functions

1. Develops medical staff bylaws, rules and regulations, and policies and procedures, per DoD, DHA, and BUMED directives.

2. Provides oversight of the quality of care, treatment, and services delivered by providers who are credentialed and privileged at their command.

3. Provides oversight of the credentialing and privileging processes.

4. Reviews applications and makes recommendations directly to the privileging authority for medical staff membership with clinical privileges.

5. Considers input from all sources, including focused professional practice evaluation (FPPE), ongoing professional practice evaluation (OPPE), and peer review, concerning the appropriateness of clinical privileges requested by health care practitioners.

6. Recommends to the privileging authority specialty all facility-specific criteria for staff appointments with clinical privileges.

7. Provides recommendations and justifications to the privileging authority regarding credentialing and privileging actions.

8. Documents MEC actions by preparing and maintaining meeting minutes that include, but are not limited to:

a. Convening of meetings

b. Meeting attendance

c. Recommendations and justification regarding credentialing and privileging actions

d. Rationale to support recommendations regarding deviations from this instruction

9. Oversees the completion and submission of the performance appraisal report (PAR) for all health care providers practicing within the command.

10. Responsible for evaluating the FPPE and OPPEs of all providers and determining actions for performance improvement actions to ensure patient safety.

11. Seeks amplification and clarification, and makes recommendations to the privileging authority regarding provider professional performance when there is reason to believe the provider is not performing within his or her delineated clinical privileges; not abiding by policies, procedures, and bylaws, per BUMEDINST 6010.30 and DHA-PM 6025.13, Volumes 3 & 4; or not practicing within acceptable standards of care.

12. Ensures professional staff monitoring is performed, per BUMEDINST 6010.30, DHA-PM 6025.13, Volumes 3 and 4, and OPNAVINST 6320.7B/MCO 6320.4.

13. Assists in developing, reviewing, and recommending actions on local policies and procedures for providing health care services, as needed.

14. Works collaboratively with the Chief Medical Officer to develop initiatives and ensure compliance with applicable policies for all privileged providers.

c. Credentials Review Committee. [If applicable, a description of the command's specific information about the Credentials Review Committee, including its function, size, composition, scope of responsibilities and delegated authority can be inserted here. For example, where workload dictates, the privileging authority may delegate credentialing and privileging functions to the Credentials Review Committee to serve as a subcommittee of the MEC. Such delegations may include, but are not limited to, FPPE and OPPE activities. The MEC retains responsibility for oversight and endorsement of the activities of the Credentials Review Committee.] The Credentials Review Committee membership must be as listed in subparagraphs 3d(2)(a) through 3d(2)(c) of this enclosure:

(1) The Credentials Review Committee Chair is selected from among the membership of the MEC and appointed by the privileging authority.

(2) Credentials Review Committee members are nominated by the MEC and appointed by the Credentials Review Committee Chair.

(3) Only privileged licensed independent providers permanently assigned to the command may be appointed to the Credentials Review Committee.

d. Senior Medical Officers, Department Heads must:

(1) Be providers with clinical oversight responsibilities and active clinical privileges, and either current board certification by the appropriate specialty board or must have comparable experience and credentials to providers assigned within their area of responsibility.

(2) Brief all providers applying for a medical staff appointment with clinical privileges on the local Credentialing and Privileging Program. Ensure all assigned staff receives appropriate orientation and allowed opportunities for continuing education (CE).

(3) Continuously monitor and document the professional clinical performance, conduct, and health status of staff members to ensure they provide health care services consistent with clinical privileges and responsibilities. Monitor quality management and medical staff activities for providers assigned, and complete PARs for those providers. Maintain OPPE data for all licensed independent providers. Ensure FPPEs are implemented and completed

appropriately for new providers upon checking into the command and in circumstances outlined in this policy. Ensure the OPPEs are conducted regularly, and aggregated data is documented at a minimum of once every six months for all providers.

(4) Ensure non-privileged providers, clinical support staff, and other non licensed personnel providing health care services are assigned appropriately and receive appropriate clinical supervision.

(5) Maintain approved staff appointments with delineated clinical privileges on providers assigned in either electronic or paper form. Ensure providers' privileging information is readily available to all internal personnel for informational purposes. For non-trainee, non-privileged providers practicing under supervision (i.e., clinical psychologists and social workers who have not fulfilled clinical hours required for degree), the plan of supervision must be maintained in the department as well as in the provider's permanent credentials record.

(6) Recommend departmental, specialty, and facility-specific criteria for staff appointment and reappointment with clinical privileges.

(7) Make recommendations for medical staff appointment with delineated clinical privileges based on the applicant's professional qualifications, health status (i.e., ability to perform), current competence, verified licensure, education and training, and National Practitioner Data Bank query.

(8) Use provider-specific results of quality management and risk management monitoring activities when making recommendations for staff appointments with clinical privileges.

e. Command Surgeons must:

(1) Continuously monitor the professional clinical performance, conduct, and health status of clinical department heads to ensure they provide health care services consistent with clinical privileges and responsibilities.

(2) Monitor quality management and medical staff activities for clinical department heads assigned to the directorate, and complete a PAR for those practitioners.

(3) Maintain OPPE data for all department heads under their directorate. Coordinate with the medical services professional to ensure FPPEs for department heads are implemented and completed appropriately.

(4) Monitor the credentialing and privileging process within their directorates.

f. Organized Medical Staff. All military (i.e., Active and Reserve Components) and civilian physicians, dentists, allied health providers, and advanced practice nurses who hold

independent clinical privileges are eligible for appointment to the organized medical staff. BUMEDINST 6010.30, DHA-PM 6025.13, Volumes 3 and 4, and DoD Instruction 6025.13 provide additional information. All privileged providers will:

(1) Initiate an application for membership to the medical staff and request the broadest scope of clinical privileges commensurate with their professional qualifications, level of current competence, and the facility's ability to support the privileges requested. Those who fail to maintain the required credentials and qualifications in BUMEDINST 6010.30, and DHA-PM 6025.13, Volume 4, or do not request such privileges, are subject to processing for separation for cause, per SECNAVINST 1920.6D, for military personnel or administrative, or disciplinary action, per SECNAVINST 12752.1A, for civilian personnel.

(2) Comply with applicable professional staff policies, procedures, and bylaws, per these medical staff bylaws.

(3) Ensure the accuracy and currency of all credentials and privileging information reflected in their credentials record (i.e., licensure status, board certification, and privilege status at other facilities).

(4) Immediately inform the privileging authority via the medical services professional of any change in status of any professional qualification, including health status, which could impair their ability to provide safe, competent, and authorized health care services.

(5) Immediately disclose (within seven calendar days) to the privileging authority, via the medical services professional, any change in their professional qualification, to include investigations or actions by any State licensing board or certification agency. Failure to timely disclose such information may be considered professional misconduct and a basis to initiate a clinical adverse action.

(6) Immediately disclose (within seven calendar days) to the privileging authority, via the medical services professional, any change in their health status that may prevent or impact the provider's ability to provide safe health care. Written medical clearance may be required from the treating physician to remain engaged in clinical patient care.

(7) Perform health care services within the scope of either the privileges granted by the privileging authority or the written plan of supervision for those providers required to practice under supervision.

(8) Participate in professional CE programs. [Command may specify minimum number of CE requirements in conjunction with respective State licensing requirements here and they may be broken down by specialty.]

(9) Actively support and participate in facility quality management activities and meetings as required.

(10) Provide the appropriate documentation to clarify or to remove any credentialing discrepancies or missing information of any type. All credentialing discrepancies or missing information requires satisfactory resolution. In the absence of required credentialing information or clarifying documentation, the privileging application is considered incomplete, and therefore cannot be processed.

(11) Provide accurate and current information and evidence of professional qualifications.

(12) For providers with infectious diseases (e.g., hepatitis B virus, hepatitis C virus, or the human immunodeficiency virus, etc.), refer to enclosure (3) of BUMEDINST 6010.30, for specific provider requirements to report their health status to each facility or command where they will be engaged in patient care activities.

4. Qualifications for Appointment to the Medical Staff. All licensed independent providers listed in enclosure (4) of DHA-PM 6025.13, Volume 4 are eligible for appointment to the medical staff. Licensed independent providers must have clinical privileges to be appointed to the medical staff. Medical staff appointments expire upon the provider's detachment from the command due to permanent change of station, end of employment or contractual agreement, medical command closure, retirement, or release from active duty. Procedures related to clinical adverse actions affecting privileges based on clinical incompetence, impairment, or professional misconduct are described in DHA-PM 6025.13, Volume 3.

5. Credentialing and Privileging Process. All policies pertaining to the credentialing and privileging process are defined in BUMEDINST 6010.30. [If applicable, a brief description of any of the command's specific credentialing and privileging process can be inserted here.]

6. Privileging Categories. All policies pertaining to the credentialing and privileging process are defined in BUMEDINST 6010.30.

7. Privileging Criteria

a. The master privilege list is contained in the Centralized Credentials Quality Assurance System and consists of specialty-specific privileges. Changes to the master privilege listing can be initiated by the applicable specialty leader but must be coordinated with DHA. Each master privilege listing contains two categories of privileges: core and non-core.

b. Core Privileges constitute the expected baseline scope of care for a fully trained and currently competent practitioner of a specific health care specialty. These privileges must be applied for and granted as a single entity. Since core privileges constitute a baseline scope of care, not all core privileges are required or expected to be exercised at all times in every medical command. The FPPE is utilized when providers have not had the opportunity to practice any of the core privileges for an extended period, due to limitation of the provider's practice location.

Privileges, per OPNAVINST 6320.7B/MCO 6320.4, must be relevant to a given medical command. Privileging authorities must inform providers in a timely manner of any command-specific policies or procedure restrictions that preclude providing health care services within the core privileges. Command limitations will be determined by the department, endorsed by the MEC, approved by the privileging authority, and reviewed annually. The core privileges are not to be modified locally. Changes to the designation of core privileges can only be made by the applicable specialty leader.

c. Non-core privileges are itemized, command-specific privileges that are relevant to the specific health care specialty. Additionally non-core privileges fall outside the general core scope of care due to the level of risk and specialty training necessary; the requirement for unique medical command support staff or equipment; or the level of technical sophistication required to support the privilege. Non-core privileges may be requested and granted on an item-by-item basis. Criteria for granting non-core privileges must be developed by the department, endorsed by the MEC, approved by the privileging authority, and reviewed annually. Non-core privileges may be modified locally to reflect the scope of care the medical command can support and expects to provide.

d. Departmental specific criteria for each non-core privilege support at the command must be reviewed and updated annually.

e. In instances where the expected scope of care is very limited or significantly less than the full core privileges, the medical command may grant itemized privileges to be exercised exclusively at its medical command.

f. Providers, to the degree permitted by their license, training, the law, and DoD, DHA, or DON rules and regulations, are authorized and expected to render such care as is necessary to save or protect the welfare of individuals in an emergency. Accordingly, emergency privileges are automatically awarded to providers by virtue of their staff appointment, negating the need for individual or specific delineation of emergency privileges. The provision of this paragraph does not negate the requirement for providers assigned to provide emergency care services to hold appropriate clinical privileges or be appropriately supervised if practicing under supervision.

8. Histories and Physical Examinations

a. A medical history and physical examination must be completed and documented by a privileged licensed independent provider, per their clinical privileges.

b. The practitioners listed in subparagraphs 8b(1) through 8b(6) of this enclosure are authorized to perform a medical history and physical examination:

(1) Physicians who hold clinical privileges may perform the history and physical examination.

(2) Oral and maxillofacial surgeons who hold clinical privileges may perform the history and physical examination on those patients.

(3) Dentists who hold clinical privileges are responsible for the patient's history and physical examination as it relates to dentistry.

(4) Podiatrists who hold clinical privileges are responsible for the part of their patient's history and physical examination as it relates to podiatry.

(5) Other practitioners who are permitted to provide patient care independently may perform the history and physical examination, if they hold core privileges in their clinical specialty.

(6) IDCs who are appropriately certified may perform history and physical examinations as allowed by their scope of practice.

c. Periodic Health Assessments, used to ensure individual medical readiness of Navy and Marine Corps Active and Reserve Component Service members, may be approved by a physician, advanced nurse practitioner, or physician assistant who hold clinical privileges. IDCs who are appropriately certified may also approve if allowed by their scope of practice.

9. Medical Record and Documentation Requirements

a. [If applicable, command-specific requirements for medical and dental records and documentation may be provided in local rules and regulations, additional policies can be added to this section of the medical staff bylaws.]

b. Medical and dental records must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results. A good medical or dental record should permit another medical staff member to assume care of the patient at any point in their course of treatment. Entries must be dated, timed, legible, signed, and include provider's National Provider Identifier number. Failure to complete medical records per local medical staff rules and regulations may result in an administrative action, to include a possible clinical adverse action.

10. Voting Members of the Medical Staff

a. [Describe the command's rules for identifying members who are eligible to vote. Describe the command's requirements for meeting quorum.]

b. All providers appointed to the command's MEC are eligible to vote on matters related to the command's organized medical staff and quality of care. Although consensus is desired for all committee actions, a simple majority vote is sufficient to forward recommendations. Minority opinions should be included in the minutes.

11. Election or Appointment to the Medical Staff

a. Privileged providers of the medical staff are eligible for nomination and appointment to officer positions.

b. Any officer position who fails to satisfactorily comply with obligations outlined in these medical staff bylaws is subject to removal from their positions by the privileging authority. Such removal should be reflected on the provider's PAR and fitness report.

12. MEC Officer Positions. [Describe command-specific MEC officer positions. Subparagraphs 12a and 12b are provided as an example.]

a. Membership to the MEC includes the listed positions (if applicable):

(1) Chair, MEC or President of the Medical Staff

(2) Vice Chair, MEC or Vice President of the Medical Staff

(3) Chair, Credentials Review Committee

(4) A provider for medical specialties

(5) A provider for surgical specialties

(6) A provider for aviation medicine (as needed)

(7) An allied health provider

(8) A provider for dental specialties

(9) The performance improvement physician advisor

(10) An advanced nurse practitioner

b. Non-Voting Membership (if applicable)

(1) Senior Medical Department Representative

(2) Medical Services Professional

(3) Chief Nursing Officer, Director of Nursing Service, or Nursing Executive Committee Chair

(4) IDC Program Director or IDC Program Manager

c. The MEC Chair and Vice Chair positions will be appointed by the privileging authority following a nominative process facilitated by the command's organized medical staff (all licensed independent providers appointed to the medical staff are eligible to vote). All other officer positions will be selected by the MEC and appointed by the MEC Chair.

d. MEC Chair and Vice Chair positions should be no less than one year in duration but would preferably be two years to ensure continuous stable leadership. When staffing and billeting permits, the MEC Vice Chair should be appointed as Chair upon the current Chair's tenure completion. A new Vice Chair will be elected and appointed no less than six months prior to the current MEC Chair's tenure completion.

13. Adoption and Amending the Medical Staff Rules, Regulations, and Policies. [Describe the commands process for adopting and amending the medical staff bylaws, local rules and regulations, and other local policies.]

a. Medical staff have the responsibility to formulate, to review at least biennially, and to recommend to the privileging authority, any changes to the medical staff bylaws, rules, regulations, policies and procedures, and amendments as needed, which must be effective when approved by the privileging authority.

b. Review and document constructive comments by the members of the staff and obtain a two-thirds vote of the voting staff at a regular or special meeting of the staff, provided a quorum is present. Notice of meeting must contain express reference to the review of these proposed bylaws.

c. An amendment must be effective when approved by the privileging authority.

d. MEC Chair and Vice Chair positions should be no less than one year in duration but would preferably be two years to ensure continuous stable leadership. When staffing and billeting permits, the MEC Vice Chair should be appointed as Chair upon the current Chair's tenure completion. A new Vice Chair will be elected and appointed no less than six months prior to the current MEC Chair's tenure completion.

14. Clinical Adverse Actions. All policies and procedures pertaining to the clinical adverse action process (i.e., summary suspension, investigation, peer review panel, proposed or final adverse privileging decisions, hearing, and appeal) are defined in volume 3 of enclosure (3), of DoD Instruction 6025.13.

MEC Chairperson Approve or Disapprove	Privileging Authority Approve or Disapprove
_____ Date	_____ Date