



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 6320.66E
BUMED-M3B6
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BUMED INSTRUCTION 6320.66E

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: CREDENTIALS REVIEW AND PRIVILEGING PROGRAM

- Ref:
- (a) DOD Directive 6025.13 of 4 May 2004
 - (b) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation Manual for Hospitals (NOTAL)
 - (c) JCAHO Accreditation Manual for Ambulatory Care (NOTAL)
 - (d) BUMEDINST 6320.67A
 - (e) SECNAVINST 5210.8D
 - (f) BUMEDINST 6010.13
 - (g) SECNAVINST 1920.6C
 - (h) DON Civilian Human Resources Manual, Subchapter 752
(<http://www.donhr.navy.mil/donchrm/default.asp>)
 - (i) OPNAVINST 6400.1B
 - (j) SECNAVINST 5720.42F
 - (k) SECNAVINST 5211.5E
 - (l) OPNAVINST 1120.4
 - (m) OPNAVINST 1120.5
 - (n) OPNAVINST 1120.7
 - (o) OPNAVINST 1120.8
 - (p) BUMEDINST 7042.1
 - (q) SECNAVINST 5210.16
 - (r) BUMEDINST 6300.8
 - (s) DOD Directive 5154.24 of 3 Oct 2001
 - (t) BUMEDINST 6000.2D
 - (u) BUMEDINST 6010.17B
 - (v) U.S. Navy Diving Manual, volume I (NOTAL)
 - (w) U.S. Navy Diving Manual, volume II (NOTAL)
 - (x) OPNAVINST 6320.7
 - (y) SECNAV Policy Memo of 6 Jan 2006
 - (z) CDC MMWR 40(RR08); 1-9; 12 July 1991

1. Purpose. To update and reissue policy and procedures for the Credentials Review and Privileging Program for the Department of the Navy (DON), per references (a) through (c) and (w), and as part of the DON clinical quality management program. Adverse privileging actions, monitoring, and reporting of practitioner or clinical support staff misconduct and due process (fair hearings and appeals) are addressed in reference (d). References (e) through (z) provide additional guidance. This is a complete revision and must be read in its entirety.

2. Cancellation. BUMEDINST 6320.66D.
3. Quality. Quality health care is a priority for Navy Medicine and includes:
 - a. Ensuring the people who deliver health care in our system are properly trained, competent and able to provide high quality health services.
 - b. Ensuring robust provider competency management processes are in place, supporting continuous quality improvement processes.
4. Background. Reference (a) provides that:
 - a. The Secretary of the Navy
 - (1) Has policy oversight of the Clinical Quality Management Program (CQMP) within DON.
 - (2) Recommends changes in the Military Health System (MHS) CQMP to the Secretary of Defense through the Assistant Secretary of Defense for Health Affairs (ASD(HA)).
 - (3) Ensures the Chief, Bureau of Medicine and Surgery (BUMED) complies fully with reference (a). Chief, BUMED, as the corporate privileging authority, has the authority to establish Navy requirements for licensure, credentials review, and clinical privileging of all DON practitioners assigned to fixed medical and dental treatment facilities, fleet units, and Marine Corps operational forces (references (u) and (w)). This includes the authority to designate specific program support responsibilities to the Chief of Naval Operations and the Commandant of the Marine Corps.
 - (4) Establishes, through the Chief of Naval Operations and the Commandant of the Marine Corps, the key elements of a CQMP for those operational air, ground, and fleet clinics not accredited by a nationally recognized body such as JCAHO.
 - b. Health care provider credentials and privileging activities are a key element of the DON CQMP.
5. Applicability. This instruction applies to all military (active duty and reserve) and civilian health care practitioners and clinical support staff (as defined in section 5), including those assigned, employed, contracted, or under resource sharing agreements and clinical support agreements with DON activities or who are enrolled in a Navy-sponsored training program.

6. Clinical Privileges. As required by JCAHO standards and directed by reference (a), Chief, BUMED serves as the governing authority and is designated the corporate privileging authority for all DON practitioners. The following are designated representatives of Chief, BUMED and are authorized to grant professional staff appointments with clinical privileges:

a. Medical regional commanders (RC), Navy Medicine East (NME), Navy Medicine West (NMW), and Navy Medicine National Capital Area (NCA), are designated privileging authorities for fixed medical and dental treatment facilities (MTFs/DTFs) within their area of responsibility (AOR). The RC may further delegate privileging authority for practitioners assigned to an MTF/DTF to the facility commanding officer or Medical Center deputy commander, as appropriate.

b. The designated privileging authority for practitioners assigned to, or deployed with, fleet/line units, is the Command Surgeon, Commander U.S. Fleet Forces Command (CUSFFC). Command Surgeon, CUSFFC may further delegate privileging authority to the type commander Fleet Surgeon or Force medical officer. Medical Department officers who serve as the privileging authority and who seek privileges in their operational assignment will request privileges from the next higher level in their AOR.

c. The designated privileging authority for all practitioners assigned to Marine Corps operational forces, including Functional Area Code (U) (FAC (U)) health care providers, is the Medical Officer of the Marine Corps (TMO), who may further delegate to the Marine Forces, Force Surgeons at the component (MARFOR) and Marine Expeditionary Force (MEF). Medical Department officers who serve as the privileging authority and who seek privileges in their operational assignment, will request privileges from the next higher level in their AOR.

d. The designated privileging authority for practitioners assigned to non-clinical billets, (i.e., BUMED, TMO, CUSFFC) who are authorized to seek a staff appointment with clinical privileges in an MTF or DTF, is the commanding officer of the MTF or DTF where such health care services are performed.

e. The designated privileging authority for Navy Reserve practitioners is the Commander, Navy Medicine Support Command (NMSC).

f. The designated privileging authority for practitioners assigned to the Naval Operational Medicine Institute is the commanding officer. The commanding officer will request privileges via the Commander, NMSC.

g. Requests for any other delegation of privileging authority will be considered under unusual circumstances. All such requests must be forwarded to Chief, BUMED via the cognizant privileging authority listed above for approval.

h. NMSC will provide direct oversight of the Navy's Credentials Review and Privileging program. This provision of direct oversight applies to all military (active duty and reserve) and civilian health care practitioners and clinical support staff (as defined in section 5), who are assigned, employed, contracted, in a Navy sponsored training program, or under partnership agreement with any DON designated privileging authority.

i. Authority to take adverse privileging action resides at the signature level at which the member's privileges were approved and may not be further delegated. Reference (d) provides additional guidance regarding adverse privileging actions.

7. Confidentiality

a. All personnel shall comply with reference (a).

b. Credentials and privileging files may appropriately contain documents that are not medical quality assurance records such as criminal investigative reports, indictments, court-martial records, or nonjudicial punishment records. When considering written requests from regulatory or licensing agencies for copies of records that contain such documents, the procedures in reference (k) must be followed to determine which documents are releasable.

c. In all disclosures, care must be taken to protect the privacy interests of other providers and patients following the procedures in reference (j).

d. Requests by regulatory or licensing agencies for information regarding permanent adverse privileging actions or reportable misconduct must be referred to the Chief, BUMED via the Staff Judge Advocate.

8. Responsibilities

a. The Chief, BUMED is responsible for technical professional evaluation and execution of the credentials review and privileging program within the guidelines of this instruction. Chief, BUMED shall:

(1) Ensure certifications of professional qualifications required by references (l) through (o) are based on verified credentials documents, identified in the individual credentials file (ICF) and individual professional file (IPF).

(2) Establish, in coordination with chiefs of the appropriate corps and the specialty leaders, standardized clinical privilege sheets, which prescribe both core and supplemental privileges reflecting the currently recognized scope of care for each health care specialty.

(3) Ensure privileging authorities, when granting clinical privileges, confirm that the practitioner requesting clinical privileges possesses the required qualifying credentials and is currently competent to exercise the privileges granted.

(4) Ensure commands that lack either adequate numbers of assigned professional staff or the expertise within the command to meet the requirements of this instruction receive the technical support and assistance necessary for compliance.

b. The Commander, Navy Recruiting Command (COMNAVCRUITCOM), per reference (a), shall ensure the requirements of this instruction are met by all commands under his or her cognizance.

c. The Commander, Navy Reserve Force (COMNAVRESFOR), per reference (a), shall ensure the requirements of this instruction are met by all commands under his or her cognizance.

9. Fees. Appropriated funds may be used to pay fees and expenses to obtain professional credentials, or required verifications per reference (p) and Title 5, United States Code (USC), section 5757. This authority is discretionary; it is not an entitlement or benefit. Navy policy is that fees associated with obtaining and maintaining basic qualifying licenses or credentials are a condition of employment and the responsibility of the individual provider.

10. Policy. The DON recognizes the importance of quality of health care services and depends on the coordinated performance between the Medical Staff leaders and the command's performance improvement activities to ensure health care quality. The potential consequences of unqualified or impaired health care providers or provider misconduct are so significant that complete verification of credentials and complete control of the clinical privileging process is imperative. Licensure, certification, or registration is a qualification for employment as a privileged uniformed health care provider in the military health care system and is required throughout the period of employment regardless of assignment, billet type, or duties and responsibilities, e.g., clinical, research, executive medicine or business administration. Since licensure, certification, or registration is an employment and commission qualification requirement, this requirement remains in effect even if the individual moves from direct patient care into a non-clinical assignment or duties. DOD policy, reference (a), states all licensed, independent health care practitioners shall be subject to credentials review and shall be granted a professional staff appointment with delineated clinical privileges by a designated privileging authority before providing care independently. To be eligible for a

professional staff appointment with clinical privileges, practitioners must possess a current, valid, unrestricted license, certificate, or exemption, or be specifically authorized to practice independently without a license, certificate, or exemption.

a. Privileging authorities must measure and periodically assess (at intervals not to exceed 2 years) the clinical performance and conduct of all assigned health care providers following this instruction.

b. Privileging authorities must maintain an Individual Credentials File (ICF) on all health care practitioners, whether holding a staff appointment with privileges, practicing under a plan of supervision, or enrolled in full-time inservice training and an Individual Professional File (IPF) on all clinical support staff per this instruction. Additionally, commanding officers of fixed MTFs and DTFs must maintain ICFs and IPFs on health care providers who are assigned to other activities in which there are no designated privileging authorities, as designated by the Chief, BUMED. Disposition of ICFs and IPFs shall follow reference (e) and this instruction.

c. Privileging authorities must maintain a mechanism, separate and distinct from the ICF, containing practitioner specific information generated through the organization's quality management activities. The performance appraisal report (PAR) must include workload (productivity), peer review, outcome indicators, and medical staff quality management activities for all health care practitioners providing direct patient care services (see Appendix A).

d. Privileging authorities shall grant clinical privileges to health care practitioners using standardized, specialty specific privilege sheets contained in this instruction. These privilege sheets reflect the currently recognized scope of care appropriate to each health care specialty. Commanding officers shall ensure health care practitioners provide care consistent with their approved clinical privileges.

e. Privileging authorities shall ensure that eligible health care practitioners, upon reporting for clinical duty, request the broadest scope of core and supplemental privileges commensurate with their level of professional qualification, current competence, and the ability of the facility to support the privileges requested. Practitioners assigned as commanding officers or executive officers are not required to request or maintain privileges during their tour due to limited time constraints for clinical duties and responsibilities. When the commanding officer or executive officer's credentials and current competence support clinical practice, they may apply for privileges within their specialties or for primary care medical officer privileges, or itemized privileges, regardless of prior privileges held. Such application offers maximum flexibility for commanding officers and executive officers who desire to maintain clinical expertise while fulfilling their primary duties. Eligible health care practitioners may hold more than one set of privileges if they meet the above

requirements. Health care practitioners who are not commanding officers or executive officers who do not maintain required qualifications or do not request such privileges may be subject to:

(1) Separation for cause under reference (g) for military personnel.

(2) Administrative action including termination of employment under reference (h) for civilian employees.

Commanding officers shall ensure practitioners conform to this guidance, initiate timely administrative action when required, and provide practitioners the resources and training necessary to meet their prescribed responsibilities.

f. Privileging authorities shall assign clinical support staff clinical responsibilities commensurate with their ability to perform (health status), licensure or certification, education and training, and current competence. Clinical support staff who do not maintain required qualifications or current competence are subject to processing for separation for cause under reference (g) for military personnel or administrative action to include termination of employment for civilian employees per reference (h).

g. Interns shall not be granted clinical privileges. Health care practitioners enrolled in residency or fellowship programs will not be granted clinical privileges in their training specialty but may apply for and be granted clinical privileges in a health care specialty in which they are fully qualified. Granting staff appointments with clinical privileges to residents and fellows should be the exception rather than the rule, have minimal impact upon the training program, and be considered only to maintain clinical competence or meet a mission-essential requirement as determined by the unit commander. DON treatment facilities may employ and grant staff appointments with clinical privileges to civilian practitioners who are currently enrolled in graduate medical education (GME) programs only if the practitioner meets all the following criteria:

(1) All clinical requirements of the current program have been completed.

(2) Current training program responsibilities are limited to research activities.

(3) Employment sought for purpose of maintaining clinical skills.

(4) Written approval to be employed has been granted by the training program director.

h. Privileging authorities shall assign non-trainee practitioners who fail to qualify for clinical privileges and are required to practice under supervision duties commensurate with their health status, licensure or certification, education and training, and current competence.

i. Practitioners not qualified for clinical privileges within 1 year after completion of training may be processed for separation for cause under reference (g) for military personnel or subjected to administrative action including termination of employment under reference (h) for civilian employees, or under the terms of their contract or agreement for contract, resource sharing agreement, or clinical support agreement practitioners.

j. Health care practitioners who have a potentially infectious disease or who are undergoing treatment or evaluation for a temporary medical condition that may impact their ability to provide safe patient care will be temporarily reassigned to non-direct patient care activities. This administrative reassignment is not an adverse action.

(1) The limitation of privileges of a practitioner infected with the human immunodeficiency virus (HIV), solely based upon a risk of disease transmission to a patient, is considered administrative and is not an adverse privileging action. (Example: An HIV-infected surgeon who is outwardly healthy, but who is restricted from performing exposure-prone invasive surgical procedures due to a risk of provider-to-patient HIV transmission.)

(2) The limitation or revocation of privileges of a practitioner infected with the HIV virus as a result of medical impairment caused by acquired immune deficiency syndrome (AIDS) is considered an adverse privileging action. (Example: An HIV-infected provider who has become physically debilitated to the point he or she can no longer practice.)

k. Before allowing a practitioner infected with the HIV or Hepatitis B virus, or similar communicable life-threatening infectious disease, to perform an exposure-prone invasive procedure, a privileging authority must evaluate each individual case using current Centers for Disease Control and Prevention (CDC) guidelines contained in reference (z). At a minimum, an expert review panel should advise the privileging authority under which circumstances, if any, the provider may perform exposure-prone invasive procedures. Preparation for these procedures must include notifying prospective patients of the practitioner's seropositive status.

l. Health care providers whose professional impairment or misconduct may adversely affect their ability to provide safe, quality patient care must be immediately removed from direct patient care activities under the provisions of reference (d).

m. Impaired providers, as defined in section 5, paragraph 14, must have their clinical practice reviewed by the Executive Committee of the Medical Staff (ECOMS), Executive Committee of the Dental Staff (ECODS), or directorate, as applicable.

n. Independent Duty Corpsmen (IDC), diving officers, master divers, diving supervisors, and deep sea diving medical technicians, who by skill designation or job classification and current competence are qualified to provide health care services, but who are not health care providers as defined in section 5, paragraph 12, are authorized to provide care as outlined in references (i), (v), and (w). The above are not eligible to participate in the privileging process, but may provide services only under supervision.

o. Privileging authorities must investigate, without delay, allegations of health care provider impairment (physical, mental, or professional), misconduct, substandard performance, or moral or professional dereliction, including reportable misconduct, per references (a) and (d).

11. DOD directives, instructions, and memoranda can be found electronically on the internet at: <http://www.dtic.mil/whs/directives>. The Office of the ASD(HA) policy documents can be found at: <http://www.ha.osd.mil/policies/default.html>.



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SECTION 1

ROLES AND RESPONSIBILITIES

1. General. The corporate responsibility of the Chief, BUMED to establish direction for the DON multi-institutional system in maintaining an effective credentials review and privileging program is consistent with the responsibilities exercised by civilian health care governing bodies. The regional commanders, the Medical Officer of the Marine Corps, and Command Surgeon, Commander, U.S. Fleet Forces Command serves as extensions of Chief, BUMED, functioning as regional governors for treatment facilities and operational medical units under their cognizance.
2. JCAHO Requirements. This instruction complies with the governing body and medical staff standards of references (b) and (c).
3. Credentials Review and Privileging Program. All DON organizations providing health care shall establish a credentials review and privileging program per this instruction.
4. Privileging Authorities
 - a. Per references (a) and (x), privileging authorities and senior medical department representatives shall exercise the necessary controls considered prudent and reasonable to ensure:
 - (1) Health care practitioners are appropriately granted staff appointments with clinical privileges.
 - (2) The quality of health care provided by privileged practitioners and clinical support staff is measured, assessed, and maintained at the highest level.
 - (3) Health care practitioners practice within the scope of their approved clinical privileges.
 - (4) Non-privileged practitioners and clinical support staff are qualified to perform assigned duties.
 - (5) Non-privileged practitioners are appropriately supervised.
 - (6) All health care providers meet the licensure, certification or registration requirement regardless of assignment, billet type or duties and responsibilities.

b. Privileging authorities may encounter circumstances that, in their judgment, require deviation from this instruction. In those cases the following guidance is offered:

(1) Have a sound, supportable reason for the deviation.

(2) Document rationale for the deviation.

(3) Ensure the quality of care delivered to the patient is not compromised.

(4) Notify the Deputy Chief of Staff - Operations, BUMED, of the deviation and any other policy impact that may constrain the overall mission.

5. The Deputy Chief of Staff – Operations, BUMED

a. Has responsibility for administration and technical oversight of the credentials review and privileging program.

b. Develops and maintains instructions implementing the DON credentials review and privileging program.

c. Provides policy support and assistance regarding credentials review and privileging.

d. Maintains liaison with external agencies, including DOD, other services, and civilian bodies.

e. Assigns MTFs/DTFs ICF and IPF maintenance responsibility for health care providers assigned to activities without professional affairs support capability or outside the DON.

f. Assigns MTFs/DTFs to provide technical assistance for commands without adequate medical or dental staff available to advise the privileging authority.

6. The Staff Judge Advocate to the Chief, BUMED

a. Provides oversight and guidance on medico-legal aspects of the credentials review and privileging program with an emphasis on adverse privileging actions per reference (d).

b. Develops and maintains instructions implementing the DON program for monitoring and reporting adverse privileging actions, incidents of reportable misconduct, and separation or termination of employment due to disability of health care providers.

7. Office of the Medical Inspector General. Provides oversight of the credentials review and privileging program, identifies areas that need policy development and identifies undesirable or unintended policy constraints through the inspection process.

8. Medical Regional Commanders, Navy Medicine East (NME), Navy Medicine West (NMW), and Navy Medicine National Capital Area (NCA), serve as the privileging authorities for those MTF/DTF commanding officers in their region.

9. Command Surgeon, Commander, U.S. Fleet Forces Command and the Medical Officer of the Marine Corps

a. Per references (a), (x), and this instruction, shall ensure operational commanders develop and implement a credentials review and privileging program and monitor compliance by their subordinate commands. Commanders may consolidate the technical and administrative support for subordinate commands, and elect to have a fleet-wide coordinated credentials review and privileging program to meet operational needs.

b. Ensure compliance with the credentials review and privileging program by all subordinate commands.

c. Aid effective implementation through education and technical assistance.

10. Commander, Navy Medicine Support Command (NMSC)

a. Acts as the centralized credentials review and privileging authority for Navy Reserve health care practitioners and maintains Reserve ICFs and IPFs.

b. Coordinates and monitors implementation of the Centralized Credentials Review and Clinical Privileging Program and associated processes for licensed or certified active duty, Selected Reserve, and civilian health care providers within the Navy Medical Department.

c. Provides technical support on credentials review and privileging matters.

d. Implements and maintains the Centralized Credentials and Quality Assurance System (CCQAS) database of DON health care providers.

e. Completes National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) queries on appropriate practitioners upon initial appointment and/or the granting of clinical privileges, at the 2-year reappointment, or more frequently if indicated.

f. Maintains ICFs or IPFs of providers transferring to non-clinical billets or administrative duties when their commanding officer is not a privileging authority and they are not going to request privileges locally.

g. Provides coordination and training for Medical Staff Services Professionals (MSSP) to include assistance and guidance associated with the use of current and future program procedures and technology.

h. Maintains liaison with external agencies, including DOD, other services, and civilian institutions regarding credentials and privileging program process issues.

i. Monitors and reports on the clinical qualifications for all DON active duty and Selected Reserves through the CCQAS database.

11. Commanding Officers of Authorized BUMED Activities

a. Serve as the privileging authority for health care practitioners under their cognizance.

b. Issue local implementing directives. Branch facilities are not expected to have a separate credentials review and privileging program but are to participate in the parent command's program. A sample format is included as Appendix C.

c. Establish mechanisms to ensure individual practitioners function within the scope of clinical privileges granted.

d. Appoint the Chairman, executive committee of the medical/dental staff.

12. ECOMS/ECODS

a. Per references (b), (c), (f), and (u) ECOMS and ECODS are required for medical and dental commands, respectively. All other privileging authorities must also provide a mechanism for medical or dental staff involvement in the credentials review and privileging process. This function shall be performed by a body of providers appointed by the privileging authorities designated in paragraph six of the basic instruction from among the privileged licensed independent practitioners under their cognizance.

b. If the professional staff includes non-physicians or non-dentists, representation on the committee from among these practitioners is recommended, especially when matters concerning their peers are under consideration.

c. The chairperson must be a senior member of the professional staff.

d. For small commands, including the operational forces, the professional staff as a whole may serve as and fulfill the functions of the ECOMS and ECODS. This instruction recognizes there are alternative methods of organizing management of operational medical departments to meet operational requirements.

e. All members of the medical staff are eligible for appointment or election to the ECOMS/ECODS. A medical staff member actively practicing cannot be considered ineligible based solely on the professional specialty or discipline. Committee membership includes representation from branch clinics and clinical directorates, as applicable and feasible.

f. ECOMS/ECODS functions:

(1) Oversees the credentials review and privileging process.

(2) Reviews and endorses applications for professional staff membership with clinical privileges.

(3) Considers input from all sources, including peer review, concerning the appropriateness of clinical privileges requested by health care practitioners.

(4) Recommends to the privileging authority specialty and facility-specific criteria for staff appointments with clinical privileges.

(5) Documents committee actions by preparing and maintaining minutes that include, but are not limited to:

(a) Convening of meetings.

(b) Meeting attendance.

(c) Recommendations and justification regarding credentials review and privileging actions.

(d) Rationale to support recommendations regarding deviations from this instruction as addressed in paragraph four of this section.

(6) Oversees the completion and submission of Appendix A.

(7) Seeks amplification and/or clarification, and makes recommendations to the privileging authorities regarding practitioner professional performance when there is reason to believe the practitioner is not performing within his/her delineated clinical privileges, not abiding by policies, procedures and bylaws per reference (u), or not practicing within acceptable standards of care.

(8) Ensures professional staff monitoring is performed following references (a) through (c) and (f).

(9) Assists in developing, reviewing, and recommending actions on policies and procedures for providing health care services.

(10) Ensures clinical competence.

13. Credentials Committee

a. In facilities where workload dictates, the privileging authority may delegate credentials review and privileging functions listed in paragraph 16d(1) through (3) in this section to a separate Credentials Committee, to serve as a subcommittee of the ECOMS or ECODS. The ECOMS or ECODS retains responsibility for oversight and endorsement of the activities of the Credentials Committee.

b. The Credentials Committee membership shall be as follows:

(1) The chairperson is chosen from among the membership of the ECOMS or ECODS and appointed by the privileging authority.

(2) Members are nominated by the ECOMS or ECODS and appointed by the privileging authority.

(3) Only privileged licensed independent practitioners permanently assigned to the command shall be appointed, with the following exception: Inactive Navy Reserve and non-physician and non-dentist health care practitioners who have staff appointments at the command are eligible for appointment to the committee to assist in the credentials review and privileging process of their peers. Document all committee actions per paragraph 12f(5) in this section.

14. Medical Staff Services Professionals

a. Are assigned on a permanent or collateral duty basis depending on the workload of the facility.

b. As the technical experts on credentials and privileging issues, render administrative and clerical assistance to the ECOMS or ECODS and the Credentials Committee, as applicable. Advise the governing body and leadership on credentials and privileging matters. Large treatment facilities are expected to augment the MSSP with clerical assistance and professional staff support necessary to comply with program requirements.

- c. Maintain ICFs and IPFs, program directives, instructions, forms, Credentials Committee minutes and working papers.
- d. Interface with outside agencies to obtain required reports, e.g., NPDB/HIPDB queries.
- e. Assist in the preparation of committee minutes, process privilege and staff appointment application and notification letters and privilege reappraisal documents, verify credentials information, maintain documentation of trends based on quality management activities, and prepare peer review panel and appeal process documents.
- f. Ensure necessary correspondence, messages and reports received and transmitted are complete, accurate, and meet the requirements of this instruction.
- g. Maintain a tracking system for the internal processing of documents relating to credentials review, staff appointment, and clinical privileges status.
- h. Assist in the preparation and annual review of facility-specific departmental criteria with appropriate department heads, thus ensuring criteria are appropriate to support the granting of clinical privileges.
- i. Submit required information on credentials and privileging to the NMSC.
- j. Monitor and track licensure, certification, and registration status for all uniformed health care providers regardless of assignment, billet type, or duties and responsibilities, e.g., clinical, research, executive medicine or non-clinical billets.

15. Clinical Directors

- a. Monitor the credentials review and privileging process within their directorates.
- b. Assume department head credentials and privileging responsibilities when their department heads' staff appointments with delineated clinical privileges are being initially granted, renewed or appraised.

16. Department Heads

- a. Continuously monitor the professional performance, conduct, and health status of department staff members to ensure they provide health care services consistent with clinical privileges and responsibilities.
- b. Ensure non-privileged practitioners, clinical support staff, and other personnel providing health care services in the department are under appropriate clinical supervision.

- c. Maintain copies of approved staff appointments with delineated clinical privileges on practitioners assigned to their departments. For non-trainee, non-privileged practitioners practicing under supervision (e.g., clinical psychologists and social workers who have not fulfilled clinical hours required for degree), the plan of supervision shall be maintained in the department file as well as in the ICF.
- d. Recommend departmental, specialty, and facility-specific criteria for:
 - (1) Initial staff appointment with clinical privileges.
 - (2) Active staff appointment with clinical privileges.
 - (3) Active staff reappointment, affiliation, or temporary appointments with clinical privileges.
- e. Make recommendations for staff appointment with delineated clinical privileges based on the applicant's professional qualifications, health status (ability to perform), current competence, verified licensure, education and training, and NPDB/HIPDB query.
- f. Use practitioner-specific results of quality management and risk management monitoring activities when making recommendations for professional staff appointments with clinical privileges.
- g. Monitor quality management and medical staff activities for individuals assigned to their department, using information received from command's information management system, to complete Appendix A (PAR) as described in Section 2.

17. Individual Health Care Providers

- a. Initiate an application for membership to the professional staff and request the broadest scope of privileges commensurate with their professional qualifications, level of current competence, and the facility's ability to support them. Those who fail to maintain qualifications or do not request such privileges are subject to processing for separation for cause under reference (g) for military personnel or to administrative action including termination of employment under reference (h) for civilian personnel.
- b. Comply with applicable professional staff policies, procedures and bylaws per reference (u).
- c. Ensure the accuracy and currency of all credentials and privileging information reflected in his/her ICF or IPF, e.g., licensure status, board certification and privilege status at other facilities.

- d. Immediately inform the holder of their ICF or IPF of any change in status of any professional qualification, including health status, which could impair their ability to provide safe, competent, authorized health care services.
- e. Perform health care services within the scope of either the privileges granted by the privileging authority, the assigned clinical responsibilities in the case of clinical support staff, or the written plan of supervision for those practitioners required to practice under supervision.
- f. Participate in professional education programs, e.g., CME programs. These programs can be sponsored through a hospital or professional organization and are used as an adjunct to maintaining clinical skills, current competency, and contingency preparedness. Participate in professional education programs must be documented in the credential file.
- g. Actively support and participate in facility quality management activities.

SECTION 2

PROCEDURES AND REQUIREMENTS FOR AUTHORIZING, DEFINING, AND APPRAISING THE SCOPE OF CARE PROVIDED BY HEALTH CARE PRACTITIONERS

1. General. All health care provided by health care practitioners must be specifically authorized and periodically appraised. Privileging authorities must not permit practitioners to diagnose, initiate, alter, or terminate regimens of health care, independently or under supervision, except as provided for in this instruction.

a. The authority for practitioners to independently diagnose, initiate, alter, or terminate regimens of health care is conveyed only through the issuance of professional staff appointments, i.e., appointment or reappointment to the medical or dental staff. A professional staff appointment requires the practitioner to adhere to the professional staff policies, procedures, and bylaws of the facility, per reference (u), and the code of professional ethics of their profession. Professional staff appointments must be accompanied by delineated clinical privileges defining the scope and limits of practice authorized. The procedures and requirements of this section are intended to comply with the intent of the standards for professional staff appointments of the JCAHO, references (b) and (c).

(1) The privileged practitioners at an MTF/DTF constitute the professional staff and are defined as the medical or dental staff, respectively. Professional staff appointments will be referred to as medical staff appointments or dental staff appointments as applicable to the treatment facility, e.g., a dentist appointed to the professional staff of an MTF is granted a medical staff appointment.

(2) The medical or dental staff appointment type reflects the relationship of the provider to the medical or dental staff. A professional staff appointment may not be granted in the absence of the granting of clinical privileges.

(3) Professional staff appointments with clinical privileges may only be granted or renewed by the privileging authorities designated in this instruction. Privileging authorities will grant professional staff appointments with clinical privileges to practitioners only after consideration of the practitioner's verified license status, current competence, professional education and training, past professional performance, ability to perform and results of the NPDB/HIPDB queries. Periods of clinical inactivity greater than 2 years constitute evidence of a lack of current competence unless information to the contrary is provided. The ability or capacity of the MTF or DTF to support the clinical privileges requested and the health care demands placed on the treatment facility must also be considered when granting or renewing professional staff appointments.

(4) Practitioner eligibility for professional staff appointment and reappointment with clinical privileges is based on the practitioner meeting predetermined department, specialty, and facility-specific criteria developed by the department head, endorsed by the ECOMS or ECODS, and approved by the privileging authority.

(5) Professional staff appointments terminate upon the practitioner's detachment from the command due to permanent change of station (PCS), termination of employment or contractual agreement, facility closure, retirement, or release from active duty without affiliation with the Navy Reserve. Those practitioners released from active duty who immediately affiliate with the Navy Reserve, will have their appointment continued upon application to NMSC.

(6) Detailed procedures for adverse termination of professional staff appointments, suspension, denial, reduction, or revocation of clinical privileges due to substandard care or misconduct are described in reference (d).

(7) Care must be taken to ensure initial and active staff appointments are not allowed to lapse. Should this occur, the privileging authority must prepare a letter to the practitioner, with a copy filed in the ICF, addressing:

(a) Inclusive dates of the lapse.

(b) Administrative, non-adverse nature of the lapse. If the lapse is noted during application processing, address the lapse in the comment section of the privileging authority's endorsement of the application.

b. Providers in full-time inservice training programs providing health care services, must be appropriately supervised by a licensed independent practitioner granted appropriate clinical privileges. Written descriptions of the role, responsibilities, and scope of practice for providers enrolled in inservice training programs must be defined for each trainee-year level by program directors at each MTF/DTF, using criteria endorsed by the executive committee for graduate medical education and approved by the commanding officer. The criteria used must specifically address the treatment facility, training program, year level, scope of care, evaluation criteria, frequency of evaluations, and supervision of the practitioner trainees. MTF/DTF policies must delineate those trainees enrolled in the inservice training program who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a clinical supervisor.

c. The provision of health care by non-privileged, non-trainee practitioners must be authorized and defined by a command-approved plan of supervision, specific to the practitioner, that contains the following elements:

(1) Scope of care permitted.

(2) Level of supervision, as defined in section five, to be imposed. The level of supervision imposed is the prerogative of the practitioner's commanding officer or officer in charge, unless that authority is specifically delegated to the department head by the commanding officer or officer in charge.

(3) Identification of supervisor.

(4) Evaluation criteria.

(5) Frequency of evaluations.

d. Practitioners who have been clinically inactive for more than 2 years are, in due consideration for patient safety, presumed not currently competent and must undergo a period of practice under supervision. Practice must comply with the provisions of paragraph 1c above. A practitioner who has practiced under a plan of supervision, and otherwise meets the criteria for an active staff appointment, may be granted an active staff appointment without first receiving an initial staff appointment.

e. Once granted an initial, active, or affiliate staff appointment with clinical privileges by a privileging authority designated in this instruction, a practitioner is eligible to provide health care services at all other DON treatment facilities using the ICTB. Compliance with this instruction results in each practitioner having a single privileging authority.

2. Clinical Privileges

a. Clinical privileges define the limits of patient care services a practitioner may render. Privileges may be granted with or without an accompanying appointment to the professional staff. Except as noted below, clinical privileges are delineated using the clinical privilege sheets in Appendices E through H. Practitioners apply for privileges using the privilege sheets applicable to their basic specialty, e.g., neurosurgeons use the neurosurgery privilege sheets, general dentists use the general dentistry privilege sheets and general surgeons use the general surgery privilege sheets. Practitioners who are fully trained in more than one specialty, e.g., subspecialists or dual-trained individuals, are eligible to apply for privileges using all applicable privilege sheets. Practitioners applying for privileges under a contract or resource sharing agreement and clinical support agreement, to perform health care services in only one department, are granted privileges consistent with their current competence, license status, education and training, ability to perform, the scope of care provided in the department, and the scope of care delineated in the contract or agreement. For example, a general surgeon also qualified as a primary care physician, who is contracted to perform health care services only in an emergency

room, should seek and normally be granted primary care privileges only. Additional emergency medicine privileges, with current competency, can be either itemized or added as supplemental to the primary care core list.

b. The DOD-issued policy guidelines regarding privilege categories: Regular privileges--grant permission to independently provide medical care for a period not to exceed 24 months; temporary privileges--time limited, infrequent, granted for a pressing patient need; and, supervised privileges (plan of supervision)--granted to non-licensed or non-certified providers who cannot practice independently. Note: Command consultants will be granted clinical privileges with or without the staff appointment prior to providing patient care, treatment or services.

c. Each of the specialty-specific privilege sheets in Appendices E through H contains two categories of privileges, core and supplemental.

(1) 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. Because they constitute a baseline scope of care, not all core privileges are required or expected to be exercised at all times in every facility. Privileges per references (b) and (c) must be relevant to a given facility. Privileging authorities must inform practitioners in a timely manner of any facility-specific policies or procedure restrictions that preclude providing the health care services defined by core privileges. These facility privilege restrictions (limitations) are annotated by two asterisks (**) on the core privilege sheet. The asterisks denote the facility cannot support that skill. The core privilege sheets are not to be modified locally. Changes to the core privilege sheets can be made only by the Chief, BUMED, following review by the appropriate specialty leader and chief of the appropriate corps. Criteria, including education and training requirements, for the granting of core privileges are contained in Appendices E through H.

(2) Supplemental privileges are itemized, facility-specific privileges that are relevant to the specific health care specialty, but lie outside the core scope of care due to the level of risk, the requirement for unique facility support staff or equipment, or level of technical sophistication. Supplemental privileges may be requested and granted on an item-by-item basis. The provider must write "yes" or "no" by each supplemental privilege on the privilege sheet using predetermined department, specialty-specific criteria. These criteria must be developed by the department, endorsed by the ECOMS or ECODS, and approved by the privileging authority. The supplemental privilege lists may be modified locally to reflect the scope of care the facility can support and expects to provide.

(3) In instances where the expected scope of care is very limited or significantly less than the full core privileges level such as, facility limitations for specified contract needs, or when there is reason to believe the applicant for privileges

may not be qualified for the full core, privileges applied for and granted may be delineated through the use of a locally-generated, itemized listing of diagnostic and treatment clinical skills, and thus are not transferable within the DON health care system. Such itemized privileges are not corporate in nature. The granting of staff appointments with itemized delineated privileges (less than the core privileges) should be for positions or contracts that specifically call for very narrow scopes of care. Examples of situations where using itemized listings to delineate where clinical privileges may be appropriate include, but are not limited to:

(a) When uniformed practitioners, whose previous privileges were less than the core for their specialty, report for duty, e.g., following an adverse action.

(b) When granting a practitioner a very limited scope of care, e.g., contract or civilian practitioners whose contracts or position descriptions define a scope of care significantly less than the applicable core.

(c) When privileging foreign national local hire (FNLH) practitioners as described below.

d. FNLH practitioners may apply for and be granted medical or dental staff appointments with clinical privileges if they possess a current, valid, unrestricted license (or the equivalent) to practice their specialty granted by the country in which the MTF or DTF is located. The staff appointments with clinical privileges granted to FNLH practitioners are specific to the local granting facility and are not corporate in nature, i.e., they cannot be used to practice at other DON treatment facilities. This limitation is not intended to reflect adversely on the competency of FNLH practitioners, however, the requirements of the status of forces agreements preclude imposing additional privileging requirements on FNLH practitioners.

e. Canadian practitioners who have graduated from an accredited Canadian medical school, and hold a Licentiate of the Medical Council of Canada, are accepted as equivalent to the Accreditation Council for Graduate Medical Education accredited graduate trained in a U.S. hospital. The Commission on Accreditation of Dental and Auxiliary Educational Programs of the American Dental Association accepts graduates of a dental school accredited by the Commission on Dental Accreditation of Canada of the Canadian Dental Association, as equivalent to accreditation. They may apply for and be granted core or supplemental privileges upon receipt of a State license.

f. Practitioners, to the degree permitted by their license, training, the law, or DON rules and regulations, are authorized and expected to render such care as is necessary to save the life or protect the welfare of individuals in an emergency situation. Accordingly, emergency privileges are automatically awarded to practitioners 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 practitioners assigned to provide emergency care services to hold appropriate clinical privileges or be appropriately supervised if practicing under supervision.

3. Application for Initial Appointment with Clinical Privileges

a. Whenever practitioners apply for a staff appointment with clinical privileges they must be briefed on the local credentials review and privileging program by the prospective department head. The MSSP provides the applicant with a staff appointment and clinical privileges application package, including at a minimum, a personal and professional information sheet (PPIS), Appendix J, an application for staff appointment with clinical privileges, Appendix K, and the applicable privilege sheets. The applicant is provided copies of, or access to, and agrees in writing to abide by the local credentials review and privileging directive, the professional staff policies, procedures, and bylaws per reference (u), and if applicable, a code of ethics. The code of ethics may be included as a component of the staff policies and procedures. The applicant shall submit a signed statement pledging to ensure or provide for continuous care of his or her patients.

b. Applicants for initial staff appointment (their first application within the Navy health care system) must complete each section of the PPIS, Appendix J, at the time of application. If a section is not applicable, enter N/A. The PPIS must identify the treatment facility and must be signed and dated by the practitioner.

c. Applicants request delineated clinical privileges using the applicable privilege sheets with the assistance of their department head; the department head shall be guided by the predetermined specialty-specific criteria. Requested privileges, modified and granted to meet and conform to the specific health care delivery demands and capabilities of the facility, are not to be construed as adverse as defined in reference (d).

(1) For practitioners reporting from DON treatment facilities, the applicant's detaching PAR, (Appendix A) serves as a letter of reference from and evidence of demonstrated competence at the detaching treatment facility.

(2) For new accessions, recalls to active duty, interservice transfers, Navy Active Duty Delay Specialists (NADDS) and Full-Time Outservice (FTOS) trainee practitioners, the application information is compared to the credentials information forwarded by BUMED.

(3) All Selected Reserve practitioners, including direct accessions, shall apply to the Centralized Credentials Review and Privileging Detachment (CCPD), NMSC for an initial staff appointment with clinical privileges.

(4) For civil service, contract, resource sharing agreement, and clinical support agreement practitioners entering the DON system, the application information is compared to the complete, verified credentials information obtained for inclusion in the practitioner's ICF, before employment or contracting.

(5) Appendix O provides a sample format for requesting information required to ascertain the current competence of applicants from agencies or treatment facilities outside the DON system.

d. References (a) through (c) require the health status of applicants for staff appointments are considered at the time of appointment to determine if any contraindications exist. The department head must document the physical and mental health status of the applicant was considered during the application process as part of his/her endorsement for staff appointment. A physician, e.g., department head, or appropriate licensed independent practitioner, will confirm the applicant's statement of the ability to perform privileges requested, on page K-3 of Appendix K, Sample Application for Professional Staff Appointment with Clinical Privileges, below the applicant's signature.

e. The MSSP and the department head compare the information provided through the application process with the applicant's ICF or the ICTB, confirming the presence and verification of all required documentation. It is the provider's responsibility to provide the appropriate documentation to clarify or remove any credentials discrepancies, i.e., red-flags. All documentation discrepancies require satisfactory resolution. The medical staff will not act on an application that is not complete. Incomplete applications shall not qualify for an appointment recommendation, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. If the applicant does not have a Navy ICF, one must be generated per section 4. Health status consideration by the department head and other parties may be accomplished through a variety of means, including, but not limited to, review of:

(1) A statement from the applicant's physician or a report of a physical examination indicating the applicant is free of mental or physical impairments.

(2) The applicant's statements regarding health status on the application for privileges and the PPIS, including updates.

(3) The PARs from previous commands.

(4) Responses to requests for credentials and privileging information from institutions or agencies external to the current treatment facility.

4. Granting of Initial Staff Appointments

a. Practitioners applying for staff appointment and clinical privileges who are new to the Navy health care system or who, although clinically active elsewhere, have not held an active staff appointment, must first be granted an initial staff appointment. The initial staff appointment period is intended to provide an opportunity for the practitioner to demonstrate to the privileging authority an understanding of and compliance with the facility's policies, procedures, and bylaws per reference (u). Practitioners who have been clinically inactive for more than 2 years, in due consideration for patient safety, are presumed not currently competent and must undergo a period of practice under supervision. Practice under supervision is to be guided by a written plan, described in paragraph 1 of Section 2. A practitioner who has practiced under a plan of supervision, and otherwise meets the criteria, may be granted an active staff appointment without first receiving an initial one.

b. The privileging authority grants initial staff appointments with clinical privileges:

(1) After review of the applicant's credentials (professional education and training, license status and history, consideration of health status, NPDB/NPDB query, and current clinical competence) has been completed. There will be credentials that cannot be primary source verified due to medical school closures, destruction of documents, etc. In these cases, every attempt must be made to primary source verify the credential. If unable to verify, a memo must be placed in the ICF, where the document is or would have been, with all appropriate information, i.e., person or organization contacted with their title, date, telephone number, reason credential cannot be verified, and any additional information. At this point the ICF is considered complete, with regard to this information, and may be forwarded for action.

(2) After applicable department head endorsement of the practitioner's application for staff appointment with delineated clinical privileges, the privileging authority may require additional endorsements.

(3) For a period not to exceed 1 year.

(4) In writing. A sample format is provided in Appendix K. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

c. After the practitioner was granted an appointment, upon receipt of orders indicating imminent deployment, the MSSP shall prepare an ICTB generated from the centralized computer database, and forward it to the contingency assignment. A copy of the current ICTB shall be maintained in Section 2 of the ICF.

d. The privileging authority must assign a proctor, usually the department head, to monitor the professional conduct and clinical performance of each practitioner with an initial staff appointment. The proctor assists the department head in the preparation of the PAR, Appendix A, before the expiration of the initial staff appointment. The proctor's monitoring activities vary with the scope of privileges granted and may include, but are not limited to:

(1) Review of ongoing monitoring and evaluation activities conducted as part of the facility's quality management program.

(2) Additional record reviews above and beyond the scope of ongoing monitoring and evaluation activities.

(3) Direct or indirect observation.

e. When, as determined by the practitioner's department head, the provider has demonstrated clinical competence and compliance with the policies, procedures, and bylaws per reference (u), and has met the applicable criteria for staff appointment and clinical privileges, the department head forwards a completed, endorsed PAR. This instruction mandates the PAR is completed, and forwarded with the application for active staff appointment with clinical privileges at least 60 days before the expiration of the initial, active, or affiliate staff appointment.

f. For practitioners not assigned, employed, or contracted to an MTF or DTF full-time, it may be difficult to satisfy the clinical workload criteria required to qualify for an active staff appointment. In cases where the practitioner is providing health care at civilian treatment facilities during the initial appointment period, it is both appropriate and recommended to solicit and consider clinical performance information from these other facilities in determining current clinical competence, using a format similar to Appendix O.

g. The practitioner is not required to complete the entire initial appointment period if demonstrated competence justifies an earlier active staff appointment. The practitioner, in consultation with the department head, must submit an application for active staff appointment, Appendix K, when the criteria for clinical privileging and active staff appointment are met.

h. The initial staff appointment period is a period of independent practice, not a period of practice under supervision. However, the degree and intensity of surveillance, monitoring, and oversight required during the initial appointment period is required to ensure patient safety while evaluating the practitioner's current clinical competence. Activities designed to ensure patient safety while evaluating the practitioner's competence are not to be construed as adverse privilege actions.

5. Granting of Active Staff Appointments

a. Active staff appointments are granted under one of three circumstances:

(1) After an initial appointment period, requiring endorsement by at least the department head, ECOMS or ECODS, and the privileging authority.

(2) After a period of practice under a plan of supervision during which all of the pre-established criteria for an initial staff appointment have been met.

(3) Upon reporting to a new assignment after having held an active staff appointment within the previous 2 years at another Navy medical or dental treatment facility, requiring the endorsement of only the department head and the privileging authority. The local privileging authority may impose additional endorsement requirements.

b. The privileging authority must grant an active staff appointment with delineated clinical privileges:

(1) Upon receipt of the practitioner's application for an active staff appointment.

(2) Following a review of the ICF to determine current clinical competence, demonstrated within the preceding 2 years, supported by practitioner-specific data and information generated by organizational quality management activities during the initial staff appointment.

(3) Following an interview with the practitioner (if required by local command) by the department head, to discuss the applicant's qualifications; local policies and procedures; the applicant's requested privileges; any facility-limited privileges; and, the ability to perform requested privileges (health status).

(4) Following a review of the endorsements on the practitioner's application by the department head, directorate (if applicable), Credentials Committee (if applicable), and ECOMS or ECODS, using the appropriate endorsement page in Appendix K.

(5) In writing. Appendix K is a sample format. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

(6) For a period not to exceed 2 years.

6. Renewal of Staff Appointments with Clinical Privileges

a. Practitioners with active staff appointments should apply for reappointment to the professional staff and renewal of clinical privileges at least 60 days before the expiration of their current appointment using a format similar to Appendix K. Requests for renewal of staff appointments should include any proposed modifications to the practitioner's current clinical privileges. Applicants who have previously been granted an active staff appointment with clinical privileges need only update the information provided in the original PPIS, using a new PPIS form. Do not alter or modify original or previous forms. The application must identify the treatment facility and be signed and dated by the practitioner.

b. Reappointment is based on reappraisal of the practitioner's credentials (verified license and required certifications, professional performance, quality management information, results from NPDB/HIPDB query, judgment, clinical or technical skills, and health status) using predetermined department and specialty-specific criteria. At the time of initial appointment, reappointment, renewal, revision of clinical privileges, or expiration of license, the current license is verified with the primary source.

c. Evaluation of practitioner-specific data and information generated by organizational quality management activities are of prime importance, and it is imperative in the assessment of current competence to justify reappointment to the medical or dental staff and renewal of clinical privileges. In cases where the practitioner is providing health care at civilian treatment facilities during the appointment period undergoing appraisal, it is both appropriate and recommended to solicit and consider clinical performance information from the other facilities in determining current clinical competence, using a format similar to Appendix O. Competency management is a medical and dental staff function.

d. The practitioner's department head, or the operational equivalent, must submit a PAR in support of reappointment to the staff and endorse the practitioner's application.

e. Both the practitioner's application and the PAR, with the department head's endorsement, are reviewed and subsequently endorsed by the directorate, Credentials Committee, and ECOMS or ECODS before approval by the privileging authority. The reappointment shall be granted:

(1) For a period not to exceed 2 years.

(2) In writing. Appendix K is a sample format. The appointment is effected when the privileging authority checks the approval block and signs and dates the endorsement page of the application. A separate appointment letter is neither required nor recommended.

7. Modifications to Clinical Privileges

a. Forward requests to modify previously approved clinical privileges to the privileging authority via the department head, directorate, Credentials Committee, and ECOMS or ECODS. [Modification examples: (1) add or delete supplemental privileges to an existing core; (2) add or delete itemized privileges to an existing itemized list; (3) add or delete a core in its entirety.]

b. Include supporting documentation in requests. Improved or new skills qualifying a practitioner for an augmentation in clinical privileges may be acquired through practice under the supervision of a practitioner privileged in the new procedure or through inservice or outservice education or training.

c. Do not alter the expiration date of the practitioner's current staff appointment when modifying clinical privileges.

d. Do not accept or act upon requests for voluntary withdrawal of core clinical privileges if the practitioner is the subject of allegations of substandard care or misconduct, or for any other reason except to correct administrative errors.

e. Requests to voluntarily withdraw core clinical privileges to correct administrative errors become effective upon approval by the privileging authority.

8. Privileging Trainees on Completion of Full-Time Inservice Training Programs

a. Current competence is implicit in successful completion of a Navy internship, residency, or fellowship program. Concurrent with successful completion of a Navy postgraduate training program and licensure, the practitioner must be granted an active staff appointment with, at the minimum, core privileges specific to the training specialty, e.g., core privileges in operational medicine and primary care medicine for internships and core privileges in general surgery for general surgery residencies. Unlicensed practitioners may not be granted clinical privileges unless a waiver is obtained.

b. To maximize the functionality of multi-institutional privileging, all Navy Medical Department training related to privileging must ensure compliance with the following procedures:

(1) Ninety days before the completion of the training program, the licensed trainee must apply for an active staff appointment with clinical privileges for the specialty in which he/she is receiving training, using Appendix K. The active staff appointment with, at the minimum, core clinical privileges, shall be granted concurrent with the completion of the training program and for a period not to exceed 2 years. The unlicensed trainee will proceed to the new duty station and be placed under a Plan of Supervision until license is obtained, and verified.

(a) Because trainees are monitored and supervised throughout their training programs, an initial staff appointment is not required, i.e., the appointment granted must be an active staff appointment.

(b) This instruction mandates the formal appraisal of the trainee's current clinical competence is initiated and completed by the program director using a PAR at least 90 days before the completion of the training program. This PAR shall serve not only as an evaluation tool for the end of the training program, but also as evidence of current competence for the trainee's next duty station.

9. Privileges for all Navy Medical Department Officers Serving as the Privileging Authority or as the Senior Medical Officer to a USMC or Operational Privileging Authority

a. Practitioners who are commanding officers are not to provide health care services independently unless appointed to the medical or dental staff. Commanding officers or designated privileging authorities may not grant professional staff appointments to themselves, but may grant professional staff appointments to their executive officers. Commanding officers and executive officers whose primary duties do not allow opportunity for clinical activity in their specialty may apply for primary care medical officer privileges, or itemized privileges, if their credentials, experience, and current competence are commensurate; however, they are not required to request or maintain privileges. Privileging in such circumstances is not considered adverse and is not subject to the adverse privileging review process.

b. Commanding officers, if requesting privileges, must apply for staff appointments with clinical privileges, as follows:

(1) Use the same procedures currently required for granting appointments to other practitioners assigned to the command in the same professional category, through completion of the endorsement by the chairperson of the ECOMS or ECODS. Leave the privileging authority's signature block on the endorsement page blank.

(2) After the chairperson of the ECOMS or ECODS completes the endorsement on the application and PAR, forward the following documents to the cognizant regional medical commander, and retain copies of any originals forwarded:

(a) A copy of the practitioner's completed and verified ICF (to include recent NPDB/HIPDB query).

(b) The original, current application, including the ECOMS or ECODS endorsement page, requested privilege sheets, and updated PPIS.

(c) The original, current PAR or the last PAR completed by the COs last duty station, including the evaluation of provider-specific data and information generated by organizational quality management activities, if the application is based on an active staff appointment granted by the last duty station.

(d) Documentation of current competency if the application is for an initial, active staff appointment or a reappointment. The PAR is the competency statement concerning the provider's clinical proficiency, and must be initiated and completed 60 days prior to the renewal of privileges, or the transfer of the provider.

(e) A copy of the department, specialty-specific staff appointment and clinical privileging criteria.

(f) A copy of the relevant sections of minutes from the ECOMS or ECODS and Credentials Committee (when a Credentials Committee exists) addressing the commanding officer's application for staff appointment.

(g) The cognizant regional medical commander processes commanding officer privilege requests.

c. The cognizant regional medical commander privileging authority shall indicate an appointment decision by signing and dating the endorsement page.

d. The completed application, PAR, ICF, and related documentation shall be returned for retention and maintenance by the command's professional affairs staff.

e. The cognizant regional medical commander privileging authority shall retain a copy of the completed application and PAR.

f. Renewal requests must have the documentation listed in paragraph 9b(2) forwarded to the cognizant regional medical commander privileging authority no less than 60 days before the practitioner's current appointment expires.

10. PCS Transfer

a. Practitioners reporting for permanent duty who previously held active staff appointments with, at the minimum, core clinical privileges, are eligible for active staff appointments with clinical privileges at the gaining command without repeating an initial staff appointment period under the following conditions:

(1) The time since the expiration of the practitioner's last active staff appointment with clinical privileges does not exceed 2 years.

(2) The most current PAR verifies demonstrated current competence for the privileges requested. Appendix A must specifically address, in sections X and XI, the current clinical competency of core, and all supplemental privileges granted.

b. For supplemental privileges, the practitioner must meet the privileging criteria relevant to the requested supplemental privileges at the gaining command. Denial of supplemental privileges at the gaining command for any of the following reasons is not an adverse privileging action:

(1) Failure to meet the privileging criteria for supplemental privileges at the gaining command.

(2) The inability of the gaining MTF or DTF to support the supplemental privileges due to facility restrictions, lack of support staff, health care demands placed on the MTF/DTF that dictate the practitioner's assigned clinical duties, or equipment.

11. Health Care Services Provided at Other DON Treatment Facilities

a. There are circumstances when a practitioner granted an active staff appointment or when a clinical support staff member expects to perform health care services at a treatment facility not under the cognizance of their current privileging authority. Examples are: temporary additional duty (TAD), additional duty (ADDU), annual training (AT), active duty training (ADT), inactive duty for training travel (IDTT), active duty for special work (ADSW), or the voluntary provision of health care services. The following procedures apply in those situations:

(1) The current privileging authority MSSP will forward an ICTB, via CCQAS, at the request of the gaining command. The ICTB can be sent by message, e-mail, fax, letter, or NAVGRAM. The gaining facility's MSSP will maintain the printed ICTB and all related documentation in a file folder. This file is not, nor is it to be converted into, an ICF, see section 4.

(a) Appendix Q is used by the gaining command to identify the clinical privileges to be authorized. No additional application for privileges is necessary at the gaining facility. When practicing under the provisions of this paragraph, the practitioner functions as a member of the professional staff and participates fully in the gaining command's quality management program.

(b) The document granting the practitioner authority to practice should address any supplemental privileges currently held by the practitioner that cannot be supported by the gaining command by reason of facility or support staff limitations.

(c) If a temporary or AT, ADT, or ADSW assignment requires a practitioner to perform privileges not currently held, but for which the practitioner potentially meets the gaining facility and departmental privileging criteria, the practitioner may apply and be authorized to exercise the privileges at the gaining facility. Since each practitioner has only one privileging authority at any given time, the gaining facility must recommend and provide justification for augmentation of the practitioner's current privileges. The gaining command may then grant the practitioner's facility-specific, supplemental privileges, and must inform the practitioner's privileging authority of the action taken. The gaining command's documentation of competency, education and training, and justification for granting the supplemental privileges, shall be forwarded to the privileging authority for inclusion into the ICF, e.g., an oral/maxillofacial surgeon, whose primary assignment is at a DTF, wants to maintain overall surgical competency by performing oral and maxillofacial surgery procedures at a local naval hospital. The dentist requests appropriate clinical privileges at the MTF, and the MTF would grant the privileges. The hospital informs the DTF these privileges were granted, and forwards the appropriate documentation, e.g., application, endorsement page, and PAR, for inclusion in the provider's ICF being maintained at the DTF.

(2) The holder of the clinical support staff member's IPF informs the gaining commanding officer of the member's education and training and license status using a message, e-mail, fax, letter, or NAVGRAM in Appendix N, ICTB format, paragraphs 1, 2, 3, 5, and 6 (modified to address practice areas in which the member is currently competent, such as general medical-surgical nursing), 9 (modified to address current competency); and 10 (modified to read IPF vice ICF).

b. A practitioner is eligible to exercise privileges at all DON MTFs and DTFs if; (1) his or her clinical privileges are not currently restricted, (2) have not expired or been terminated, and, (3) meets the privileging criteria at the gaining command. The expiration date of the practitioner's current appointment is indicated on the ICTB. If supplemental privileges are expected to be exercised at the gaining facility, communication between the gaining and parent facilities will be necessary to ensure the practitioner can meet the gaining facility's specialty-specific privileging criteria for any supplemental privileges.

c. A PAR will be completed for periods exceeding 4 continuous days, and forwarded to the parent command for inclusion in the practitioner's ICF.

d. When the practitioner provides recurring services at another treatment facility, e.g., TAD or reserve drills, the ICTB is valid for the tenure of the practitioner's current staff appointment at the parent facility. A single PAR, covering the multiple duty periods, must be completed at the end of the last duty period, and must be submitted as part of the privilege reappraisal process.

e. Practitioners within their initial 1-year privileging period are not to be assigned duty to other facilities as a general rule. However, circumstances may arise that require exception to this rule, e.g., operational requirements, temporary relief of a sole practitioner assigned to an overseas, remote, or small facility, or outpatient support at nearby clinic(s) not under the same privileging authority. Practitioners holding only initial staff appointments may be assigned such duty using the procedures described above, under the following conditions:

(1) The prospective gaining facility identifies in their request the specific scope of services necessary during the duty period.

(2) After a review of the scope of service, requested relative to the inventory of practitioners onboard who could satisfy the requirement, the parent facility privileging authority documents (ICTB) the rationale for a decision the requirement can be safely met with a practitioner who has not yet been granted an active staff appointment.

(3) The gaining privileging authority acknowledges the practitioner is acceptable.

(4) If the practitioner offered is not acceptable, the parent facility nominates another practitioner, if available, or refers the request to higher authority for resolution.

12. Permanent Assignment to the Operational Forces

a. MTFs/DTFs must ensure practitioners assigned to their commands in receipt of orders to an operational assignment are currently competent and professionally qualified to support the operational forces.

(1) Prior to detachment, practitioners must have attained active staff appointments with, at a minimum, those core privileges required to function in the prospective operational assignment.

(2) The practitioner's ICF shall be forwarded to the privileging authority as prescribed in section 4, paragraph 5 of this instruction.

b. Practitioners at fixed MTFs or DTFs without core privileges required to function in their prospective operational assignment must be provided the necessary training before detachment. Use those procedures previously described for augmentation of clinical privileges. If the practitioner does not complete the required training to qualify for the operational assignment core privileges, the regional commander will be notified, the practitioner will not be transferred, and Navy Personnel Command (NPC-4415) will be notified.

c. If practitioners desire to practice at another facility while assigned to the operational forces, they may do so using the procedures described in paragraph 11a(1)(c) of this section.

13. Temporary Augmentation to the Operational Forces

a. Privileging for practitioners temporarily assigned to operational forces follows the procedures outlined in paragraph 11, subparagraphs a through e. To assure patient safety and the highest standard of medical care to our operational forces, the following procedures apply:

b. Fixed MTFs/DTFs must support the operational forces by ensuring practitioners assigned to their commands who are in receipt of TAD orders to an afloat operational assignment are currently competent, professionally qualified, and have been granted active staff appointments with, at a minimum, the core privileges required to function in the prospective TAD operational assignment. Time permitting, practitioners in receipt of TAD operational orders, who require core privileges not currently held to function in their operational assignment, must be provided the training necessary to qualify them for the required privileges before the expected date of mobilization.

c. The holder of the practitioner's ICF informs the gaining TAD operational command of the practitioner's current credentials and staff appointment with clinical privileges using the electronic CCQAS ICTB. The completion of Appendix Q format is not necessary for these specific providers. A practitioner holding a current medical staff appointment with clinical privileges can exercise the privileges aboard ship in a TAD afloat or other operational environment. It is understood the practitioner agrees not to exercise privileges that exceed the medical capabilities immediately available in the operational environment.

d. If the TAD operational assignment is of such a nature that the gaining command cannot be located to transmit an ICTB, practitioners may hand-carry their ICTB to present to the gaining operational command upon arrival.

14. Credentials Review and Privileging Process at Operational Commands

a. The principles and procedures for granting staff appointments with clinical privileges at fixed MTFs/DTFs are applicable to practitioners and privileging authorities with modifications specified in local implementing directives.

b. The privileging authorities for practitioners reporting for PCS operational assignments are in paragraph 6 of the basic instruction.

c. Practitioners reporting to operational assignments shall be granted privileges at their detaching commands, with the exception of those practitioners completing internships. Additionally, those practitioners not completing all requirements for State licensure, and therefore unable to be granted active staff appointment, will not be transferred. Because practitioners reporting to operational assignments from fixed MTFs/DTFs will have been granted an active staff appointment with clinical privileges at their detaching commands, there is no need for operational privileging authorities to grant initial staff appointments. If an individual arrives as a direct accession from a civilian internship, or residency, with a current license, he or she will be granted the initial staff appointment with clinical privileges, only after written documentation of current competency is obtained from the civilian Program Director.

15. Selected Reserve Practitioners

a. All Selected Reserve practitioners shall have their credentials reviewed and verified and shall apply for and be granted staff appointments with clinical privileges consistent with the procedures applicable to active duty practitioners by the holder of their ICF designated in section 4, paragraph 3.

b. When a Selected Reservist is assigned to IDTT, AT, or ADT involving the provision of health care services at the facility, the gaining command shall request an ICTB from the CCPD.

c. When a Selected Reservist is assigned to ADSW involving the provision of health care services at the facility, the gaining command shall request an ICTB from the CCPD.

d. When a Selected Reservist is recalled to temporary active duty the ICF is retained by the CCPD, and the gaining activity will request an ICTB from the CCPD for the duration of the recall.

16. Ongoing Assessment of Practitioner Performance

a. Documented using any mechanism the facility or operational site mandates to meet the facility's needs and operational mission. Relevant information from organizational quality management activities is considered when evaluating professional performance, judgment, and clinical and technical skills (clinical competence). Whatever mechanism is used, this practitioner-specific quality management information shall be easily accessible and maintained at the facility for the 2-year reappointment or renewal of privileges.

b. Practitioner-specific data includes:

(1) Information generated through the command's quality management activities and risk management program, i.e., process and outcome measures.

(2) Data reflecting workload (productivity).

(3) Results of peer review activities.

(4) Patient feedback data and information.

(5) Documentation of training or continuing education, including Advanced Cardiac Life Support or Advanced Trauma Life Support required to meet specialty-specific staff appointment or privileging criteria.

(6) Documentation of practitioner's ability to perform, i.e., health status (located on the PPIS) in terms of ability to practice in the area in which privileges are requested.

(7) Other practitioner-specific information used in evaluating or documenting the clinical performance of the practitioner, including appraisals of non-trainees practicing under supervision.

c. A PAR, Appendix A, shall be completed on each practitioner providing health care services by the privileging authority at intervals not to exceed 2 years and placed in the ICF. The purpose of the PAR is to permanently document the periodic appraisal of practitioner conduct, competence, and performance required by reference (a) for each separate specialty set of privileges granted. For example, if a practitioner is privileged in Family Medicine and Flight Surgery, each specialty must be separately evaluated and documented on a separate PAR. The PAR is the primary document used to support the granting and renewal of active staff appointments. Additionally, the PAR shall be reviewed at the time of fitness report preparation. Any evaluation element marked "UNSATISFACTORY" in section VI or VIII shall be accompanied by explanatory remarks placed in section XII or on attached additional sheets. Department heads are required to make appropriate comments in section X regarding the practitioner's clinical competence in practicing all privileges granted, both core and supplemental privileges in section XI. A PAR must be completed on all health care practitioners:

(1) During the latter portion of initial staff appointments.

(2) Before completing inservice graduate professional education or training programs.

(3) Sixty days prior to detachment incident to transfer, separation, termination of employment, or retirement. When the member has detached from the command

without an opportunity to review and sign the PAR, provide member with a copy of the PAR at his or her next duty station with a "date/copy to practitioner" annotated on the bottom of the original PAR filed in member's ICF.

(4) Upon completion of temporary duty exceeding 4 continuous days; permanent assignment to an operational unit; or temporary assignment to another operational unit exceeding 4 continuous days.

(5) At the time of reappointment to the professional staff.

(6) When significant new information about a detaching practitioner's performance or conduct becomes available after the practitioner detaches. In this case, a special PAR shall be completed by the appropriate department head, endorsed by the Credentials Committee, the ECOMS/ECODS, and forwarded to the practitioner's gaining privileging authority. When received by that authority, the PAR shall be reviewed and endorsed by the practitioner, gaining department head, Credentials Committee, and ECOMS/ECODS before inclusion in the practitioner's ICF. The special PAR is the appropriate vehicle to forward results of Judge Advocate General Manual Investigations (JAGMANs), civilian external peer review, or investigations into allegations of misconduct or substandard care to the gaining privileging authority. Information included on the detaching PAR need not be reiterated on the special PAR. Potentially adverse PARs must be acted upon and finalized by the sending command.

d. The mechanisms used at the facility level to gather and maintain practitioner-specific quality management data shall be handled with the same security and confidentiality precautions required for all documents generated through quality assurance programs per reference (k).

17. Support of the Armed Forces Medical Examiner (AFME) System. The AFME System provides support for medico-legal death investigations to all DOD MTFs/DTFs. The range of support includes onsite performance of autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners generally hold privileges granted by the Armed Forces Institute of Pathology (AFIP). Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their AFME credentials to the commanding officer. An application for staff appointment with clinical privileges is not required for this service (see reference (s)).

18. Health Care Services Provided by Non-DON Trainees

a. Non-DON trainees performing health care services under supervision as part of a cooperative agreement with a training institution are not eligible for a staff appointment with clinical privileges. An ICF for such practitioners is not required.

b. Documentation of the following must be maintained in the MTF/DTF professional affairs office:

(1) Written authorization from the privileging authority for the practitioner to provide a specified scope of health care services while under the supervision of a specified practitioner who holds a professional staff appointment with clinical privileges in the same or similar specialty as the trainee.

(2) The designated supervisor is responsible for over-sight, coordination, and any required follow-up care related to the health care services provided by the trainee.

(3) A copy of the evaluation completed at the conclusion of the training period.

(4) Written confirmation from the trainee's primary training institution that the practitioner's qualifying credentials required by Appendix B, as applicable, are verified.

19. Support for the Organ and Tissue Procurement Program and the Armed Services Medical Regulating System. Organ donations and transplants conducted by organ and tissue procurement teams, per reference (r), and treatment provided within Navy MTFs/DTFs by personnel assigned to the Armed Forces Medical Regulating System to patients under their care, per reference (s), are authorized to be performed without formal credentials review and privileging under this instruction. However, personnel assigned in support of these programs must present sufficient documentation (e.g., official orders, assignment letter or identification card) to the commanding officer of the MTF/DTF to establish their authorization to perform the services.

20. Telemedicine Credentials and Privileging Process. Reference (b) requires practitioners who provide patient care services via a telemedicine link sharing either total or partial responsibility for patient care, treatment, or services, (e.g., authority to write orders) to be credentialed and privileged at the originating site, (e.g., where the patient is located at the time services are rendered.) These standards do not apply to consultant services. Practitioners providing official readings of images, or specimens must be credentialed and privileged under the JCAHO contracted services standard.

SECTION 3

CLINICAL SUPPORT STAFF AND INDIVIDUAL PROFESSIONAL FILES (IPFs)

1. General. Privileging authorities shall ensure that assignments to patient care activities of clinical support staff, as defined in section 5, are based on consideration of the staff member's verified qualifying degrees and licenses (all State licenses or certifications held within the last 10 years), past professional experience and performance, education and training, health status, and current competence as compared to specialty-specific criteria regarding eligibility for defined scopes of health care services. Primary source verification (PSV) is a function under the JCAHO medical staff and human resources standards; therefore, for all clinical support staff nurses/registered dental hygienists for whom a State license, certification or registration is required by the Navy or by State statutes, the license/certification/registration shall be primary source verified upon its initiation (hire), expiration, and renewal of licensure. However, there is no requirement to primary source verify clinical support staff nursing certifications, e.g., Association of Operating Room Nurses (AORN) and Certification in Critical Care Nursing (CCRN). Privileging authorities shall ensure procedures are in place for consideration of the staff member's verified qualifying degrees, using the criteria established by the corps chiefs and directors.

a. Privileging authorities shall maintain an IPF on all clinical support staff assigned to, employed by, contracted by, or under resource sharing agreement and clinical support agreement with the command. A Privacy Act Statement (PAS), Appendix I, is to accompany each IPF. The IPF shall contain documentation described in Appendix S.

b. The items described in Appendix B, ICF and IPF shall be collected before the individual being selected is employed, contracted to the DON, or assigned clinical duties other than under direct supervision as defined in section five.

c. Responsibility for initial collection and verification of the items listed in Appendix B is as follows:

(1) For direct accessions, recalls to active duty, and interservice transfers to the DON, the Commander, Navy Recruiting Command, is responsible per section four of this instruction. The applicable professional review board appointed under references (n) and (o) shall confirm the required verifications of the credentials information.

(2) For new civil service employees, the servicing civilian personnel office shall collect and verify the required credentials information, Appendix B, and shall furnish such information to the commanding officer for review before hiring the individual.

(3) For new employees contracted directly to the MTF/DTF, the commanding officer is responsible. If the contract involves an intermediate contracting agency, that agency is held responsible. This information must be furnished to the MTF/DTF MSSP at least 30 days before the individual begins work under the contract.

d. IPFs shall contain a signed PAS, Appendix I.

2. Disposition and Maintenance of IPFs. The disposition and maintenance of IPFs follow the same guidelines for ICF disposition and maintenance in section 4.

3. Clinical Performance Appraisal. The ongoing assessment of the performance of clinical support staff assigned to clinical duties shall be generated through the organizational quality management activities (performance data and information). Upon transfer, separation, termination of employment, or retirement, and at intervals not to exceed 2 years, an appraisal of each clinical support staff member's clinical performance and conduct shall be completed with documentation placed in the member's IPF. The appraisal must identify and address, at a minimum, the following elements:

- a. MTF/DTF completing the appraisal.
- b. Identification of the member being appraised, including grade or rate, social security number (SSN), and designator, if applicable.
- c. Purpose of the appraisal (transfer, separation, periodic).
- d. Inclusive dates of the appraisal period.
- e. Clinical department assignments and scope of clinical responsibilities.
- f. Clinical activity indicators, e.g., average daily inpatient census and average number of outpatient visits.
- g. Professional development activities, e.g., participation in continuing professional education, publications, presentations, and recognition of professional achievements.
- h. Positive or negative trends identified through performance data and information, generated through the command's quality management activities.
- i. Incidents of reportable misconduct as defined in reference (d).
- j. Review of the appraisal by the appropriate director.
- k. Review of the appraisal by the member and the opportunity to make comments.

4. Disposition of Performance Appraisals. The original of the clinical performance appraisal is to be placed in the member's IPF. Upon detachment from the command, copies of all clinical performance appraisals prepared at the command are to be retained in a secure file at the command for 10 years. After 10 years, the file shall be forwarded to the provider, if current address is known, or destroyed as authorized by reference (e). The retained performance appraisals serve as a record to respond to future inquiries regarding the clinical support staff member's professional performance and staff responsibilities while assigned to the command.

5. Health Care Services Provided at Other DON Treatment Facilities. When clinical support staff members are assigned to provide health care services at a DON treatment facility other than that to which they are permanently assigned, employed, contracted, or under resource sharing agreement and clinical support agreement with, and the gaining treatment facility is under the cognizance of another privileging authority, the sending facility forwards the required credentials information using the Appendix N (ICTB) format. The information may be conveyed using a speed letter, NAVGRAM, e-mail, or message, with the appropriate blocks completed as indicated in paragraph 11 of Section 2. The gaining facility is required to provide an appraisal of the clinical support staff member to the sending facility if the assignment exceeds 4 days. A single appraisal, covering all such assignments over the sending facility's current 2-year appraisal period for the member, may be used when the member is temporarily assigned more than once to the same facility. The gaining facility shall retain a copy of Appendix N (ICTB) and the appraisal for 10 years. This file is not an IPF and is not to be converted into one. See section four, paragraph 3c(2).

6. Contingency Assignment. When a clinical support staff member has been given a contingency assignment, upon receipt of orders indicating imminent deployment, the MSSP shall prepare an Appendix N (ICTB), generated from the centralized computer database, and forward it to the contingency assignment. A copy of the current Appendix N (ICTB) shall be maintained in section II of the ICF.

SECTION 4

INDIVIDUAL CREDENTIALS FILES (ICF)

1. General. Upon accession into or employment by the DON, each health care practitioner, including military trainees, shall have credentials information collected, verified, and incorporated into an ICF, following the structure and content guidelines in Appendix R. A signed PAS, Appendix I, shall accompany each ICF. The ICF is maintained throughout the practitioner's tenure with the DON. Do not duplicate information contained in the ICF in any other files used in the administration of trainees. Compliance with this instruction results in a single, complete, verified ICF for each practitioner.

2. Collection and Verification of Credentials Documents

a. All items in Appendix B shall be collected, verified, and evaluated before an individual is selected, employed, contracted, or granted a professional staff appointment by a privileging authority of a DON MTF/DTF.

b. Responsibility for collection and verification of the items listed in Appendix B is as follows:

(1) Direct accessions, recalls to active duty, and inter-service transfers to the DON. Commander, Navy Recruiting Command is responsible per the documentation guidelines specified in this section. The Deputy Chief, Education and Training, ensures the accession package is complete before submission to the professional review board. The applicable professional review board appointment per references (l) through (o) confirms the verification of the required credentials documents.

(2) Students reporting from Armed Forces Health Professions Scholarship Program (AFHPSP) and Uniformed Services University of the Health Sciences (USUHS) programs. Gaining privileging authority is responsible.

(3) New civil service employees. Servicing Human Resources Office (HRO) is responsible. The civilian personnel office forwards the information to the appropriate privileging authority before hiring the individual.

(4) New contract practitioners. If the individual is contracted directly to the MTF/DTF, the commanding officer is responsible. If the contract involves an intermediate contracting agency, that agency is responsible and forwards the information to the gaining privileging authority at least 30 days before the individual begins work under the contract.

c. The items listed in Appendix R (ICF), plus any related new or updated information, summaries of JAGMAN investigations or liability claims in which the individual was a principle party, and PARs, must be maintained in the ICF. Summaries of information of an adverse nature, accrued during DON service and becoming available after the practitioner leaves DON service, shall be included and maintained in the practitioner's ICF.

d. The practitioner is responsible for providing accurate and current evidence of professional qualifications. This may be in the form of documents, letters of reference, statements or information provided during the accessions or credentials review and privileging process. The practitioner shall immediately inform the holder of their ICF of any change in professional qualification, including health status, which could impair their ability to provide safe, competent, authorized health care services.

e. Copies of documents provided by the practitioner being evaluated are not required to be certified true copies, but shall serve as reference documents for the verification process. References (a) requires independent PSV of the following credentials. These credentials are further described in Appendix R (ICF). Copies of documents are not required to be in the credentials file.

(1) Qualifying degree. Educational Commission for Foreign Medical Graduates (ECFMG), Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), or Fifth Pathway certificates for those graduates of foreign medical schools, other than approved schools in Canada and Puerto Rico, constitutes evidence of the qualifying degree.

(2) All clinically related postgraduate training.

(3) All professional qualifying certifications.

(4) All State licenses and certifications held within the last 10 years including all voluntary lapses of license. A current, valid, unrestricted license or certification is one which is not expired or been suspended or revoked, one in which the issuing authority accepts and considers quality assurance (quality management) information, and is not subject to restriction pertaining to that scope, location, and type of practice ordinarily granted all other applicants for similar licensure or certification in the granting jurisdiction. If the practitioner does not possess a license or certification exemption, or is not otherwise specifically authorized to practice independently without a license or certification, the practitioner shall be placed under a plan of supervision.

f. At time of appointment, reappointment to the medical staff or upon the granting or renewal of privileges, the license, relevant education/training, current competency, and board certification, shall be primary source verified. The PSV for static credentials, e.g., relevant education and training, is required only one time for those credentials that

remain static. Static credentials do not require reverification by gaining privileging authorities unless a change in the status of the credential has occurred since the last verification or some reason exists to doubt the authenticity of the credential. Licensure is primary source verified at the time of each appointment, and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate State licensing board. PSV of credentials is required to be placed in the credentials file. Copies of the credentials are not required.

g. The PSV must be independent, i.e., the member him/herself cannot complete the verification process.

h. Acceptable sources and methods of verification include:

(1) Contact with the primary source or with an agency that has obtained PSV, i.e., American Medical Association (AMA) master file for education and training. Telephonic verification is acceptable. Verification obtained by parties external to the DON that meet the DON verification standards as described is acceptable.

(2) Professional organization's web site provided that:

(a) The information is obtained directly from the professional organization's web site. Use of the web site of another recognized professional organization (such as, the Administrators in Medicine site of the Association of Medical Board Executive Directors) is permitted if it is used as the platform to reach the intended site. If the information has a disclaimer and is not encrypted, the site cannot be used as a PSV site. The MTF/DTF and, when applicable, its credentials verification office (CVO) must confirm the web site used is the professional organization's official Web site.

(b) The MTF/DTF and, when applicable, its CVO, should ensure that the source web site, when not located at and under the direct control of the professional organization, receives its information directly from the professional organization's database through encrypted transmission. When the source Web site is located at and under the control of the professional organization, the MTF/DTF and, when applicable, its CVO should ensure that the Web site does receive its information from the database by encrypted transmission and is protected from alteration by unauthorized individuals.

(c) The information on the Web site contains all of the information required for the PSV process of the specific credential.

(d) The Web site should contain sufficient information to properly identify the applicant. For example, name alone might not be sufficient to identify the applicant.

(e) The MTF/DTF and, when applicable its CVO, should be aware of the currency of information on the Web site.

(f) Information on the Web site that is supplemental to the information undergoing PSV, such as a State licensing board's Web site including information on the individual's specialty, is not to be used as PSV data, although it may be useful in evaluating the overall package of information gathered by the MTF/DTF on the practitioner.

(g) Any discrepancy between information provided by the applicant and the Web site should be followed up with the professional organization by correspondence or telephone.

(h) The fact that adverse information is not presented on the Web site should not deter the MTF/DTF from contacting the professional organization by telephone or written correspondence if the other information gathered by the MTF/DTF warrants it.

(i) All of the verifying information on credentials must be placed in the ICF.

(j) The identification of the medical staff-specialist or CVO who made the web site contact and gathered the information, as well as the date, should be entered into the Web site printout or other record of the information. If that information is, in turn, transmitted electronically to the MTF/DTF, the facility must also identify the medical staff specialist who gathered the information from the CVO, along with the date.

(k) The MTF/DTF's use of a CVO that gathers information directly from a professional organization's Web site is subject to the guidelines for the use of CVOs found in references (b) or (c). For board certifications, the official American Board of Medical Specialty (ABMS) Directory of Board Certified Medical Specialists published by Marquis Who's Who in cooperation with the ABMS; or, listings published by certifying boards may be used as verification.

(3) Listings published or released by certifying agencies, e.g., the National Commission on Certification of Physician Assistants (NCCPA); the Academy of Certified Social Workers (ACSW); and, the American Nurses Credentialing Center (ANCC).

(4) Confirmation by NMSC through CCQAS that the document has been verified.

(5) When unable to verify education and training, or qualifying degrees due to school closures or other unforeseen events, verify attempts made, persons contacted (title and telephone number), ensuing discussion, and reason verification cannot be

completed. At this point the record is considered complete and can be forwarded to the ECOMS/ECODS for action. Upon recommendation of the committee, the privileging authority may grant a staff appointment without the required verification. This decision shall be supported by a preponderance of evidence that the requirement in question has been met. The decision and justification, including letters of inquiry and telephone calls, shall be documented with a copy placed in the practitioner's ICF. Place the documentation in the same section the credential in question would have been placed if available.

i. All discrepancies require resolution through direct contact with the primary source.

j. Acceptable documentation of verification clearly identifies the:

(1) Agency, name, position, and telephone number of the person supplying confirmation of authenticity.

(2) Publication or listing, if such was the source of verification.

(3) Agency, name, position, and telephone number of the person documenting the verification.

(4) Date of verification, facility, and MSSP's signature.

k. The documentation of PSV is placed on or appended to the document being verified and placed in the ICF.

l. ICFs shall contain a signed PAS (Appendix I).

m. While the responsibility for fees required to obtain and maintain basic qualifying licenses and certificates lies with the practitioner, appropriated funds may be used to pay fees, in advance if required, to obtain verifications per reference (r).

3. Maintenance of ICFs

a. Members have only one ICF.

b. ICFs are to be maintained in a secure area. If the practitioner provides health care services at a facility not under the cognizance of the privileging authority holding their ICF, the holder of the ICF forwards the applicable credentials and privilege information to the gaining privileging authority using the format in Appendix N (ICTB).

c. All Navy Reserve practitioners' ICFs shall be maintained at the CCPD. The CCPD functions as follows:

(1) The CCPD is a department of the NMSC. The CCPD centralize the credentials review and privileging process for reservists; manages reserve ICFs and IPFs; coordinates initial privileging with MTFs/DTFs; maintains an ECOMS; renews privileges; uses the CCQAS database; and maintains archived active duty and reserve ICFs and IPFs from closed or disestablished activities and facilities for at least 10 years.

(2) ICFs and IPFs for civil service and contract providers who are also Selected Reserves shall be maintained by the CCPD. The CCPD shall provide an ICTB to the privileging authority for the facility where the reservist works.

(3) Selected Reserves shall apply for an initial staff appointment with clinical privileges to the CCPD. The period of initial privileging shall continue per this instruction. Concurrent civilian practice information shall be collected from each civilian affiliation by the CCPD and placed in the ICF.

(4) The Reserve provider shall be evaluated following all periods of clinical service in a military MTF/DTF and a PAR with an ICTB shall be submitted. The facility shall be responsible for the collection and documentation of the required practitioner-specific data and information generated by organizational quality management activities. The PAR shall be completed per this instruction. Quality management and civilian activity data and PARS shall be acted upon by the CCPD in the granting or renewing of privileges. The CCPD shall establish a credentials review and privileging committee for this purpose. The CCPD shall be queried by Navy Reserve Readiness Commands (REDCOMs) to determine if a reservist is privileged before processing training or support requests. An ICTB will be sent to the gaining command if privileged. Adverse or additional privileging action shall follow reference (d).

4. ICF Contents

- a. Only documentation specified in Appendix R may be placed in a practitioner's ICF.
- b. Practitioners have a right to obtain, review and comment upon copies of all material in their ICF. The NPDB/HIPDB queries may not be copied per the Health Care Quality Improvement Act of 1986.
- c. Before material of an adverse nature (i.e., fact or opinion which reflects negatively on personal conduct, clinical competence or performance) is placed in an ICF, the practitioner shall be provided a copy and given an opportunity to provide comments. Statements by a practitioner in reply to the adverse material must also be

included in the practitioner's ICF. Except material ordered inserted in an ICF by the Navy Surgeon General, adverse matters shall undergo peer review as defined in section five before placement in the ICF.

- d. Removal of material from the ICF may only be accomplished per reference (k).

5. ICF Disposition

- a. Privileging authorities are to retain a copy when forwarding original ICFs using the procedures described below. Upon confirmation of receipt of the original ICF, the copy may be destroyed per reference (e) or forwarded to the gaining authority for their use.

- b. For practitioners transferring on PCS orders to a DON clinical, administrative, or research assignment within the MHS, the original ICF is forwarded, return receipt requested or signature confirmation, to reach the gaining privileging authority at least 15 days before the practitioner's scheduled arrival. MSSP ensures a completed PAR, PPIS, and signed Appendix K (application) is included. If the PAR, PPIS, or privilege application is not completed prior to the transfer of the ICF, the transferring commander/commanding officer must include a letter to the gaining command explaining why the PAR or privilege application is not completed in a timely manner, and state when it will be completed. These documents may be faxed to the gaining activity to accelerate the privileging process. The ICFs of practitioners transferring to non-clinical assignments outside the MHS shall be forwarded to the NMSC with a letter informing the practitioner of the ICF location. Practitioners shall provide changes and updates of licensure status and credentials information to the holder of their ICFs. Upon subsequent assignment to a clinical billet, the holder of the ICF shall forward the ICF to the gaining privileging authority.

- c. For practitioners ordered to full-time inservice graduate education, the ICF shall be forwarded to the gaining training facility, using the procedures in paragraphs 5a and 5b above.

- d. For practitioners ordered to FTOS GME, the original ICF shall be forwarded to the NMSC with a letter informing the practitioner of its location. Practitioners are to provide changes and updates in credentials information to the holder of their ICF. The Head, Active Duty Medical and Dental Staff Services, NMSC will maintain the current license status in CCQAS. Upon completion of FTOS, the holder of the ICF shall forward the ICF to the gaining privileging authority.

e. For practitioners who have separated or terminated DON employment:

(1) If no permanent adverse privileging action or reportable misconduct exists, as defined in reference (d), the original ICF shall be forwarded to the NMSC and shall be retained in a closed status for at least 10 years. At that time it must be forwarded to the practitioner, if current address is known, or destroyed as authorized by reference (e).

(2) If permanent adverse privileging action or reportable misconduct exists, as defined in reference (d), the original ICF shall be forwarded to the Staff Judge Advocate to the Surgeon General, return receipt requested, for indefinite retention.

f. For Reserve practitioners who have separated or terminated DON employment:

(1) With no history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be retained at the CCPD for at least 10 years. At that time it must be forwarded to the practitioner, if current address is known, or destroyed as authorized by reference (e).

(2) With a history of permanent adverse privileging action or reportable misconduct, as defined in reference (d), the original ICF shall be forwarded to the Staff Judge Advocate to the Surgeon General, return receipt requested, for indefinite retention.

g. Archived ICFs and IPFs from closed facilities, should be retained or destroyed per paragraphs 5e(1) and (2) and, 5f(1) and (2) above.

h. When forwarding or disposing of ICFs, note the provisions of paragraph 6 of this section.

i. For health care providers transferring from one government contract to another, unless otherwise specified in an individual Task Order Proposal Request, the government reserves the right to transfer to the gaining contractor, the credentials of a health care worker who has been employed by/granted delineated clinical privileges on a predecessor contract without a new or additional credentialing action. This extension may only occur:

(1) Within the same command.

(2) When there is no increased clinical competency requirement of the health care worker.

- (3) When there is no significant change in the scope of clinical practice of the health care worker.
- (4) When there is no gap in performance between the contracts.
- (5) When the health care worker has had acceptable performance evaluations.

SECTION 5

DEFINITIONS

1. Abeyance. The temporary removal of a privileged practitioner from clinical duties while an inquiry into allegations of practitioner misconduct or professional impairment is conducted. Abeyances cannot exceed 28 days. A privilege abeyance is non-punitive and is not an adverse privilege action.
2. Adverse Privileging Action. The denial, suspension, limitation, or revocation of clinical privileges based upon privileged practitioner misconduct, or professional, medical, or behavioral impairment. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership is also an adverse privileging action. Providers who have been diagnosed as alcohol or drug dependent or as having an organic brain or psychotic disorder are considered impaired providers (refer to definition of impairment in this section).
3. Alcohol or Drug Abuse. The use of alcohol or other drugs to an extent that it has an adverse effect on performance, conduct, specialty, mission effectiveness, or the user's health, behavior, family, or community. The wrongful or illegal possession or use of drugs in any amount also constitutes drug abuse.
4. Clinical Privileging. The process whereby a health care practitioner is granted the permission and responsibility to independently provide specified medical or dental care within the scope of his or her licensure, certification, or registration. Clinical privileges define the scope and limits of practice for individual practitioners. Privilege categories include:
 - a. Regular Privileges. Core and supplemental privileges.
 - b. Temporary Privileges. Granted when time constraints do not allow a full credentials review. These privileges are time-limited and granted only to fulfill urgent patient care needs.
 - c. Supervised Scope of Practice. Used to identify the privileging status of non-licensed and non-certified providers who are not independent, and are placed under a Plan of Supervision.
5. Clinical Support Staff. Personnel who are required to be licensed under this instruction, but are not included in the definition of health care practitioners. This category includes dental hygienists and non-privileged nurses.
6. Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification, experience and expertise of health care providers.

7. Credentials Review. The application and screening process whereby health care providers have their credentials evaluated before being selected for DON service, employed by the DON, granted clinical privileges or assigned patient care responsibilities.
8. Credentials, Verified. Document authenticity is obtained, confirmed and verified from the primary (issuing) source (PSV) by the Military Service or a representative of the Military Service. Confirmation is independent of the practitioner; this is the key criterion. Static credentials (never change), once verified, need not be verified again if confirmation of the authenticity with the primary source is present, and appropriately documented. However, State license/certification/ registration, national certifications, NPDB/HIPDB and current competency shall be verified at every granting and renewal of clinical privileges.
9. Current Competence. Possessing adequate ability to perform the functions of a practitioner in a particular discipline as measured by meeting the following conditions:
 - a. Privileged to independently practice a specified scope of care within the past 2 years.
 - b. Authorized to practice a specified scope of care under a written plan of supervision within the past 2 years.
 - c. Completed formal graduate professional education in a specified clinical specialty within the past 2 years.
 - d. Actively pursued the practice of his/her discipline within the past 2 years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested.
 - e. Satisfactorily practiced the discipline as determined by the results of practitioner-specific data and information generated by organizational quality management activities.
10. Denial of Privileges. An adverse privileging action, which denies privileges requested by a practitioner, when those privileges are of a nature which would normally be granted at the facility to a practitioner of similar education, training, and experience occupying the same billet. A denial shall be imposed by a privileging authority only after the opportunity for a peer review hearing has been afforded the practitioner.
11. Disability (Physical). Any impairment of function due to disease or injury, regardless of the degree, which reduces or precludes an individual's actual or presumed

ability to engage in gainful or normal activity. The term physical disability includes mental disease, but not such inherent defects as personality disorders and primary mental deficiency, although they may render a member unsuitable for military duty.

12. FAC(U) Practitioners. Practitioners assigned to operational Marine Corps units ADDU to Budget Submitting Office 18 facilities to maintain clinical skills and proficiency.

13. Health Care Providers. Health care practitioners and clinical support staff collectively.

14. Health Care Practitioners (Licensed Independent Practitioners). Licensed military (active duty and reserve) and DON civilian providers (federal civil service, foreign national hire, contract, or resource sharing agreement and clinical support agreement) required by reference (a) to be granted delineated clinical privileges to independently diagnose, initiate, alter or terminate health care treatment regimens within the scope of their licensure. This includes physicians, dentists, marriage and family therapists, nurse practitioners, nurse midwives, nurse anesthetists, clinical psychologists, optometrists, clinical dieticians, podiatrists, clinical social workers, pharmacists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants (PAs). For the purposes of this instruction, individuals enrolled in training programs leading to qualification for clinical privileges and American Red Cross volunteers in any of these disciplines are also considered health care practitioners.

15. Impairment. Any personal characteristic or condition, which may adversely affect the ability of a health care provider to render quality health care. Impairments may be professional, medical or behavioral. Professional impairments include deficits in medical knowledge, expertise or judgment. Behavioral impairments include unprofessional, unethical or criminal conduct. Medical impairments are conditions which permanently impede or preclude a practitioner from safely executing responsibility as a health care provider or from rendering quality health care or any medical condition requiring convening of a medical board.

16. Intravenous Conscious Sedation (Moderate Sedation). Sedation for which there is a reasonable expectation the sedation may result in the loss of protective reflexes in a significant percentage of patients.

17. License. A grant of permission by an official agency of a State, the District of Columbia, a commonwealth, territory, or possession of the United States to provide health care within the scope of practice for a discipline. In the case of a physician, the physician license must be an active, current license that is unrestricted and not subject to limitation in the scope of practice ordinarily granted to other physicians, for a similar specialty, by the jurisdiction that grants the license. This includes, in the case of health care furnished in a foreign country by any person who is not a national of the United

States, a grant of permission by an official agency of that foreign country for that person to provide health care independently as a health care professional. Authorized licensing jurisdictions for health care personnel are specified in references (b) through (d). For the purpose of this instruction, "license" and "licensure" shall include certification and registration as appropriate for the provider type.

a. Active. An unrestricted license/registration not subject to limitation on the scope of practice ordinarily granted by the State.

b. Valid. The issuing authority accepts, investigates and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

c. Unrestricted. Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

18. Limitation of Privileges. An adverse privileging action taken under reference (d) by a privileging authority which permanently removes a portion of a practitioner's clinical privileges. A privileging authority shall impose a limitation only after the opportunity for a peer review hearing has been afforded to the practitioner.

19. Peer Review. Offers a practitioner the forum for problem solving and action as indicated. Peer review is conducted at a particular level, or tier, within the locally defined medical or dental staff organizational hierarchy. For example, in a hospital or dental center where committees are available to provide professional staff monitoring, the first or lowest level of peer review is at the committee, traditionally followed by the ECOMS or ECODS as the second level. Likewise, if these functions are performed within departments, they constitute the first or lowest level, followed by the service or directorate and ECOMS or ECODS as the second and third levels. Ordinarily, peer review is not conducted above the first level if consensus is reached. Additionally, when the consensus is reached that there are grounds for adverse action, reference (d) shall be followed.

20. Professional Staff Appointment. Formal, written authorization to perform patient care with delineation of authorized clinical privileges. Reflects the relationship of the provider to the medical staff. Appointment types include:

a. Initial Staff Appointment. The first Navy Medical Department professional staff appointment, granted for a period not to exceed 12 months, giving the practitioner the opportunity to demonstrate to the privileging authority current clinical competence and the ability to comply with the facility's policies, procedures, bylaws and code of professional ethics. This duration of time reflects the provisional (initial) staff appointment period.

b. Active Staff Appointment. Staff appointments granted to practitioners who successfully complete the initial staff appointment period. The active staff appointment period is 24 months.

c. Affiliate Staff Appointment. Granted to providers meeting all qualifications for membership in the medical staff after successfully completing the initial appointment period, but who are neither assigned organizational responsibilities nor expected to be full participants in activities of the medical staff. May apply to consultants, resource sharing personnel or part-time contracted staff. Affiliate members must conform to all medical staff bylaws. The affiliate staff appointment period does not exceed 24 months.

d. Temporary Staff Appointment. Granted in situations when time constraints do not allow full credentials review. Required when providers practicing under temporary privileges will be admitting patients. Relatively rare, used only to fulfill urgent patient care needs. The temporary staff appointment period does not exceed 30 days.

21. Revocation of Privileges. Per reference (d), an adverse privileging action undertaken by a privileging authority, which permanently removes all a practitioner's clinical privileges. A revocation may be imposed only after the opportunity for a peer review hearing has been afforded to the practitioner.

22. Supervision. The process of reviewing, observing and accepting responsibility for the health care services provided by health care providers. Levels of supervision are defined as:

a. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation and the practitioner's not exceeding the authorized scope of care.

b. Direct. The supervisor is involved in the decision- making process. This may be further subdivided as follows:

(1) Verbal. The supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care.

(2) Present in Person. The supervisor is physically present throughout all or a portion of care.

23. Suspension. An initial adverse action taken under reference (d) which temporarily removes all or a portion of a practitioner's clinical privileges. If only a portion of the practitioner's privileges is removed, it is a partial suspension. This summary action is imposed before the initiation of the peer review process.

24. Verification. Confirmation of the authenticity of health care provider credentials through contact with the issuing agency (PSV) or use of a secondary source authorized by the Deputy Chief of Naval Operations (Manpower, Personnel, and Training) (MP&T) per references (l) through (o). Verification shall be documented.

ABBREVIATIONS

AAMFT	American Association of Marriage and Family Therapy
ABMS	American Board of Medical Specialty
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ACSW	Academy of Certified Social Workers
ADDU	Additional Duty
ADSW	Active Duty for Special Work
ADT	Active Duty Training
AFHPSP	Armed Forces Health Professions Scholarship Program
AFIP	Armed Forces Institute of Pathology
AFME	Armed Forces Medical Examiner
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
ANCC	American Nurses Credentialing Center
AOA	American Osteopathic Association
AORN	Association of Operating Room Nurses
APN	Advanced Practice Nurses
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASHA	American Speech-Language-Hearing Association
AT	Annual Training
ATLS	Advanced Trauma Life Support
Au.D	Doctor of Audiology
BSN	Bachelor of Science in Nursing
BUMED	Bureau of Medicine and Surgery
C-4	Combat Casualty Care Course
CCPD	Centralized Credentials Review and Privileging Detachment
CCQAS	Centralized Credentials and Quality Assurance System
CCRN	Certification in Critical Care Nursing
CDC	Centers for Disease Control
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
CQMP	Clinical Quality Management Program
CSWE	Council on Social Work Education
CUSFFC	Commander, U.S. Fleet Forces Command
CVO	Credentials Verification Office
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Agency
DENBN	Dental Battalion
DMD	Doctor of Medical Dentistry
DO	Doctor of Osteopathy
DOD	Department of Defense

DON	Department of the Navy
DTF	Dental Treatment Facility
ECFMG	Educational Commission for Foreign Medical Graduates
ECODS	Executive Committee of the Dental Staff
ECOG	Electrocochleography
ECOMS	Executive Committee of the Medical Staff
EGD	Esophagogastroduodenostomy
ENOG	Electroneuronography
FAC(U)	Functional Area Code (U)
FMGEMS	Foreign Medical Graduate Examination of the Medical Sciences
FNLH	Foreign National Local Hire
FSSG	Force Service Support Group
FTOS	Full-Time Outservice
GME	Graduate Medical Education
HIV	Human Immunodeficiency Virus
HLTHCARE SUPPO	Health Care Support Office
HQMC	Headquarters of the Marine Corps
ICF	Individual Credentials File
ICTB	Inter-facility Credentials Transfer and Privileging Brief
ICU	Intensive Care Unit
IDTT	Inactive Duty Training Travel
IPF	Individual Professional File
IRR	Individual Ready Reserve
JAGMAN	Judge Advocate General Manual
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MARFORLANT	Marine Corps Forces, Atlantic
MARFORPAC	Marine Corps Forces, Pacific
MAW	Marine Aircraft Wing
MD	Doctor of Medicine
MHS	Military Health System
MP&T	Manpower, Personnel, and Training
MSSP	Medical Staff Services Professional
MSW	Master of Social Work
MTF	Medical Treatment Facility
NADDS	Navy Active Duty Delay Specialists
NCCPA	National Commission on Certification of Physician Assistants
NMSC	Naval Medical Support Command, Jacksonville, Florida
NOTAL	Not to all
NPC	Navy Personnel Command
NPDB/HIPDB	National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank
NRC	Nuclear Regulatory Commission
OIC	Officer in Charge

PA	Physician Assistant
PAP	Papanicolaou, G.
PAR	Performance Appraisal Report
PAS	Privacy Act Statement
PCS	Permanent Change of Station
PhD	Doctor of Philosophy
PPIS	Personal and Professional Information Sheet
PRD	Projected Rotation Date
PSV	Primary Source Verification
RC	Regional Commanders
RDH	Registered Dental Hygienist
REDCOMS	Reserve Readiness Commands
SSN	Social Security Number
TAD	Temporary Additional Duty
TMD	Tempomandibular Disorders
TMO	The Medical Officer of the Marine Corps
TTS	Through the Scope
UENMSE	Upper Extremity Neuromusculoskeletal Evaluator
USUHS	Uniformed Services University of the Health Sciences