		DELINEATION OF CLINIC	CAL PRIVIL	LEGES -	PHYSICIA	N A	ASSISTANT					
		For use of this form, se	1			/ is	OTSG.					
1. NAME (OF PROVIDE	2. RANK/0	GRADE (3. FACILITY								
be coded.	ER: Enter th For procedu	res listed, line through and initial any	criteria/appli	cations th	at do not app	oly.	egory and/or individual privilege listed must Your signature is required at the end of					
Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.												
column mai	rked "APPR	ew each category and/or individual pri OVED". This serves as your recomme ignature are required in Section II of th	endation to t									
	stetrical, su	ırgical, and psychiatric health problem		-			nt, and management of patients with general and in consultation with or direct referral to					
	·	PROVIDER CODES		SUPERVISOR CODES								
		etent to perform		1 - Approved as fully competent								
		on requested (Justification attached)					equired (Justification noted)					
	Supervision	requested sted due to lack of expertise			- Supervision		insufficient expertise					
	•	ted due to lack of facility support/mis	ssion				insufficient facility support/mission					
-	SECTION I - CLINICAL PRIVILEGES											
	D: 0		ON 1 - CLINIC	CAL PRIVI	LEGES							
Category I.	•		eneficiaries t	hat involv	es uncomplic	ateo	d illnesses or problems with low risk to					
	•	will typically be performed in Troop N			•		·					
Requested	Approved											
		Category I clinical privileges										
		a. Diagnose and treat illnesses and injuries (all categories of beneficiaries)										
		b. Order and interpret laboratory tests										
		c. Order and interpret radiographs (X-ray, CT, MRI and Ultrasound)										
		d. Prescribe and/or administer P&T Committee approved medications										
		e. Issue temporary profiles (not to exceed 30 days)										
		f. Perform complete histories and physicals (AR 40-501)										
		g. Supervision of immunizations (AR 40-562)										
		h. Nuclear and Chemical Surety evaluations (AR 50-5 and 50-6)										
Category II. Specialty Areas. Includes Category I. Requires residency or specialty training that prepares the physician assistant to perform duties, procedures or manage specific categories of patients.												
Requested	Approved			Requested	Approved							
		Category II clinical privileges				f.	Cardio-thoracic Surgery					
		a. Aviation Medicine (Aeromedical	PA)			g.	Diving/Hyperbaric Medicine (DMO/HMO)					
		b. Orthopedics				h.	Neurosurgery					
		c. Emergency Medicine				i.	Dermatology					
		d. Occupational Medicine										
		e. Cardiovascular Perfusion										
Category III	I. Procedu	es. Includes Categories I and II.	l_			1						
Requested	Approved			Requested	d Approved							
		Category III clinical privileges				e.	Administration of IV fluids					
		a. Joint aspiration/injection				f.	Nasogastric intubation					
		b. Wound care, debridement and su	ıturing			g.	Nasopharyngeal intubation					
		c. Incision and drainage of abscesse				h.	Stabilization of fractures					

d. Urethral catheterization

i. Reduction of simple extremity fractures

Category III.	. (Continued)											
Requested	Approved		Requested	Approved								
		j. Administration of anesthesia			k. First assist in major so	urgical cases						
		(1) Digital										
		(2) Local										
		(3) Intercostal										
Category IV. Inpatient Privileges. Includes Categories I, II and III. Typically requires specialty training or assignment to duties that necessitate these privileges.												
l ypically Requested	Approved	ecialty training or assignment to duties t	Requested	Approved								
		Category IV clinical privileges	110 400000		d. *Narrative summaries	;						
		a. *Admission of patients		e. *Discharge of patien		s						
		b. *Inpatient history and physical examinations										
		c. *Doctor's orders										
*Requires n	hyeician rev	iew and signature within 24 hours.										
COMMENTS												
			SIGNATURE OF PR			T						
		DATE (YYYYMMDD)										
		SECTION II - SUP	 PERVISOR'S RECOMI	MENDATIO	 N							
Approva	l as request			•	Disapproval (Specify below)							
COMMENTS		ed Approval with Modifica	tions (specify below)	1	Disappioval (specify below)							
DEPARTME	NT/SERVICI	CHIEF (Typed name and title)	SIGNAURE			DATE (YYYYMMDD)						
SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION												
Approva	l as request				Disapproval (Specify below)							
COMMENTS												
COMMITTE	E CHAIRPEF	RSON (Name and rank)	SIGNATURE			DATE (YYYYMMDD)						

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