DELINEATION OF CLINICAL PRIVILEGES - ALLERGY/IMMUNOLOGY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. FACILITY

INSTRUCTIONS:

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. 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.

SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	SUPERVISOR CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested *(Justification attached)*	2 - Modification required *(Justification noted)*
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support/mission	5 - Not approved, insufficient facility support/mission

SECTION I - CLINICAL PRIVILEGES

Category I.
Primary care provider (PCP) with limited experience and training in allergen immunotherapy and the complex immunizations utilized as the supervising physician for an allergen immunotherapy and/or immunization clinic.

Requested	Approved	
		Category I clinical privileges

Category II.
PCP with formalized training in allergy-immunology practice able to perform limited specialty-specific evaluation and/or testing procedures and treatment but requiring quality assurance review/supervision by a specialist (potentially at a distant location).

Requested	Approved	
		Category II clinical privileges

Category III.
Provider has completed an accredited Allergy/Immunology residency fulfilling all competency requirements and is able to perform the indicated specialty-specific procedures without supervision. Note: Fellows in training are privileged in Internal Medicine, Pediatrics, or Family Practice based on board certification or eligibility.

Requested	Approved	
		Category III clinical privileges

Category IV.
Provider is board certified in allergy-immunology and is able to perform the specialty-specific procedures without supervision.

Requested	Approved	
		Category IV clinical privileges

CLINICAL PRIVILEGES

Requested	Approved	
		a. Allergy-Immunology Relevant to ALL ages. Neonate (0-2 mos); Infant (2-24 mos); Pediatric (2-10 years); Adolescent (11-17 yrs); Adult (18-65 yrs); Geriatrics (> 65 yrs).
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics

SPECIAL PROCEDURES

The procedures listed below are performed on ALL ages (as specified above) UNLESS an age restriction is noted.

Requested	Approved	
		a. Complete allergy evaluation to include prick and intradermal skin testing and nasal smears
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		b. Comprehensive asthma evaluation
		(1) Spirometry interpretation
		(2) Prick & intradermal skin testing in asthmatics
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics

Requested	Approved	**SPECIAL PROCEDURES** *(Continued)*
		c. Allergen, food and/or exercise challenges
		(1) Inhalation
		(2) Oral
		(3) Parenteral
		(4) Topical
		(5) Exercise
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		d. Drug and immunization special skin testing, challenges, and desensitization procedures
		(1) Inhalation
		(2) Oral
		(3) Parenteral
		(4) Topical
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		e. Allergen Immunotherapy (All ages except neonate)
		(1) Inhalant
		(2) Insect
		(3) RUSH Immunotherapy
		Other age restrictions (if any): ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		f. Fiberoptic rhinolaryngoscopy (NOT for neonates)
		Other age restrictions (if any): ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		g. Immunologic evaluation and interpretation of diagnostic laboratory data
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		h. Special skin testing using human sera
		(1) Autologous serum testing for autoimmune urticaria
		Age restrictions (if any): ☐ Pediatric ☐ Adults ☐ Geriatrics
		i. Immunization health care delivery
		(1) For healthy individuals - all ages
		(2) For patients with complex medical problems including primary or secondary immunodeficiency disorders
		(3) For overseas travel specific requirements, including malaria diarrhea chemoprophylaxis
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		j. Immunoglobulin therapy (High dose & deficiency replacement)
		(1) Intravenous
		(2) Subcutaneous
		(3) Intramuscular
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics
		k. Complex vaccine related adverse events diagnosis and management to include medical exemption assessments
		Age restrictions (if any): ☐ Neonates ☐ Infants ☐ Pediatric ☐ Adolescents ☐ Adults ☐ Geriatrics

COMMENTS

COMMENTS *(Continued)*		
	SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - SUPERVISOR'S RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS		
DEPARTMENT/SERVICE CHIEF *(Typed name and title)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

Approval as requested ☐ Approval with Modifications *(Specify below)* ☐ Disapproval *(Specify below)* ☐

COMMENTS		
COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*