DELINEATION OF CLINICAL PRIVILEGES - DERMATOLOGY

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

PRIVILEGES PART I

Requested	Approved		Requested	Approved	
		a. History & physical examination			g. Shave biopsy
		b. KOH preparation & interpretation			h. Cryotherapy for benign keratoses & warts
		c. Oil preparation for scabies			i. Topical & parental drug therapy
		d. Tzanck preparation for herpes			j. Incision & Drainage (I&D)
		e. Local anesthesia			
		f. Punch biopsy			

PRIVILEGES PART II

Requested	Approved		Requested	Approved	
		a. Fungal culture & identification			n. Dermabrasion
		b. Dark field examination			(1) Localized
		c. Local anesthesia including regional block			(2) Full face
		d. Incisional & excisional skin biopsy			o. Chemical peels
		e. Ablative cutaneous surgery			(1) Acid peels
		(1) Cold knife			(2) Phenol peels
		(2) Electrocoagulation			(3) Other *(Specify)*
		(3) Electrodessication			p. Hair transplantation
		(4) Epilation			q. Laser therapy/surgery *(Specify Type)*
		f. Cryosurgery - benign & malignant lesions			
		g. Salabrasion			
		h. Chemotherapy			r. Wedge excision lip
		(1) Cytostatic/cytotoxic agents			s. Nail matrix surgery
		(2) Topical			t. Grafts
		(3) Injectable			(1) Punch
		(a) Local lesion treatment			(2) Split thickness
		(b) Systemic			(3) Full thickness
		(c) Immunosuppressive agents			u. Lip shave/vermilionectomy
		i. Phototherapy			v. Blepharoplasty
		(1) UVB			w. Flaps
		(2) UVA			x. Sclerotherapy
		(3) Psoralen + UVA			y. Rhinophymectomy
		j. Patch testing			z. Collagen injection
		k. Photopatch testing			aa. Interpretation of immunofluorescence, direct and indirect, on skin and mucosa.
		l. Electrolysis			
		m. Grenz ray therapy			ab. Mohs micrographic surgery

COMMENTS		
	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)*