EVALUATION OF CLINICAL PRIVILEGES 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. PERIOD OF EVALUATION (YYYYMMDD)					
		FROM	ТО				
4. DEPARTMENT/SERVICE	5. FACILITY (Name	and Address: City/Si	tate/ZIP Code)				

INSTRUCTIONS: Evaluation of clinical privileges is based on the provider's demonstrated patient management abilities appropriate to this discipline, and his/her competence to perform the various technical skills and procedures indicated below. All privileges applicable to this provider will be evaluated. For procedures listed, <u>line through and initial</u> any criteria/applications that do not apply. The privilege approval code (see corresponding DA Form 5440) will be entered in the left column titled "CODE" for each category or individual privilege. Those with an approval code of "4" or "5" will be marked "Not Applicable". Any rating that is "Unacceptable" must be explained in SECTION II - "COMMENTS". Comments on this evaluation must be taken into consideration as part of the provider's reappraisal/renewal of clinical privileges and appointment/reappointment to the medical staff.

SECTION I - DEPARTMENT/SERVICE CHIEF EVALUATION							
CODE	PRIVILEGE CATEGORY/PROCEDURE	ACCEPTABLE	UN- ACCEPTABLE	NOT APPLICABI			

CODE	PRIVILEGE CATEGORY/PI	ROCEDURE	ACCEPTABLE	UN- ACCEPTABLE	NOT APPLICABLE			
	SECTION II - COMME	NTS (Explain any rating that is "Unacceptable".)					
NIANAE AND	TITLE OF EVALUATOR	CICNATURE		DATE				
NAIVIE AND	TITLE OF EVALUATOR	SIGNATURE		DATE	YYYYMMDD)			