EVALUATION OF CLINICAL PRIVILEGES - NEUROLOGY

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 TO
4. DEPARTMENT/SERVICE	5. FACILITY *(Name and Address: City/State/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, line through and initial 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	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	Category I clinical privileges			
	Category II clinical privileges			
	Category III clinical privileges			
	Category IV (a) clinical privileges			
	Category IV (b) clinical privileges			
	SPECIAL PROCEDURES			
	a. Lumbar Puncture			
	b. Cisternal Tap			
	c. Subdural Tap *(Infant)*			
	d. Electroencephalogram (EEG)			
	e. Brain Stem Auditory Evoked Response			
	f. Visual Evoked Response			
	g. Somatosensory Evoked Response			
	h. Electromyography/Nerve Conduction Velocity (EMG/NCV)			
	i. Myelogram			
	j. Plasmapheresis			
	k. Nerve Biopsy			
	l. Nerve Block, Peripheral			
	m. Muscle Biopsy, Needle			
	n. Muscle Biopsy, Open			
	o. Chemodenervation			
	p. Ultrasound Examination of the Brain			
	q. Ultrasound Examination of the Muscle			
	r. Ultrasound Examination of Spinal, Cervical and Intracranial Vasculature			
	s. Carotid Duplex Ultrasonography			
	t. Insertion of Sphenoidal EEG Electrodes			

SECTION II - COMMENTS ***(Explain any rating that is "Unacceptable".)***

NAME AND TITLE OF EVALUATOR	SIGNATURE	DATE *(YYYYMMDD)*