EVALUATION 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. 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	PRIVILEGES PART I	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. History & physical examination			
	b. KOH preparation & interpretation			
	c. Oil preparation for scabies			
	d. Tzanck preparation for herpes			
	e. Local anesthesia			
	f. Punch biopsy			
	g. Shave biopsy			
	h. Cryotherapy for benign keratoses & warts			
	i. Topical & parental drug therapy			
	j. Incision & Drainage (I&D)			
	PRIVILEGES PART II			
	a. Fungal culture & identification			
	b. Dark field examination			
	c. Local anesthesia including regional block			
	d. Incisional & excisional skin biopsy			
	e. Ablative cutaneous surgery			
	(1) Cold knife			
	(2) Electrocoagulation			
	(3) Electrodessication			
	(4) Epilation			
	f. Cryosurgery - benign & malignant lesions			
	g. Salabrasion			
	h. Chemotherapy			
	(1) Cytostatic/cytotoxic agents			
	(2) Topical			
	(3) Injectable			
	(a) Local lesion treatment			
	(b) Systemic			
	(c) Immunosuppressive agents			
	i. Phototherapy			
	(1) UVB			
	(2) UVA			
	(3) Psoralen + UVA			
	j. Patch testing			

CODE	**PRIVILEGES PART II** *(Continued)*	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	k. Photopatch testing			
	l. Electrolysis			
	m. Grenz ray therapy			
	n. Dermabrasion			
	(1) Localized			
	(2) Full face			
	o. Chemical peels			
	(1) Acid peels			
	(2) Phenol peels			
	(3) Other *(Specify)*			
	p. Hair transplantation			
	q. Laser therapy/surgery *(Specify Type)*			
	r. Wedge excision lip			
	s. Nail matrix surgery			
	t. Grafts			
	(1) Punch			
	(2) Split thickness			
	(3) Full thickness			
	u. Lip shave/vermilionectomy			
	v. Blepharoplasty			
	w. Flaps			
	x. Sclerotherapy			
	y. Rhinophymectomy			
	z. Collagen injection			
	aa. Interpretation of immunofluorescence, direct and indirect, on skin and mucosa.			
	ab. Mohs micrographic surgery			

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

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