EVALUATION OF CLINICAL PRIVILEGES - PULMONARY DISEASE

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	PROCEDURE/SKILL	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. Tube thoracostomy			
	b. Diagnostic bronchoscopy			
	c. Interventional bronchoscopy			
	d. Bronchial brushing			
	e. Bronchial lavage			
	f. Bronchograms			
	g. Diagnostic and interventional laryngoscopy			
	h. Transthoracic needle lung aspiration and biopsy			
	i. Pleural biopsy *(closed)*			
	j. Transtracheal aspiration			
	k. Percutaneous tracheostomy			
	l. Bronchoprovocation challenge			
	m. Interpretation of:			
	(1) Pulmonary function testing			
	(2) Cardiopulmonary exercise testing			
	(3) Electrocardiograms			
	(4) Polysomnograms			
	n. Paracentesis			
	o. Pericardiocentesis			
	p. Thoracentesis			
	q. Arthrocentesis			
	r. Bone marrow aspiration			
	s. Bone marrow biopsy			
	t. Arterial puncture and cannulation			
	u. Central venous puncture *(including subclavian, internal jugular, and femoral sites)*			
	v. Pulmonary artery catheterization			
	w. Endotracheal intubation			
	x. Respirator management			
	y. Elective cardioversion			
	z. Cardiac pacemaker insertion			
	aa. Spinal tap			
	ab. Administration of conscious sedation			
	ac. Whole lung lavage under general anesthesia			

CODE	LASER PRIVILEGES	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
	a. YAG laser ablation via bronchoscopy			
	b. Photodynamic laser therapy			

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

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