DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date: 6/30/2016

REQUEST FOR REAPPOINTMENT TO THE MEDICAL STAFF

I hereby request reappointment to the medical staff of:

_____ _____ _____
(Hospital/Health Center) (Town/City) (State)

I request that my clinical privileges be:

☐ Renewed as presently granted.

☐ Increased as designated in a memorandum attached hereto.

☐ Reduced as designated in a memorandum attached hereto.

CONTINUING PROFESSIONAL EDUCATION

Describe topics, sources, and dates of all continuing education you have completed in the past year.

Current CPR, ACLS, ATLS, PALS Training Status

1. Certified in basic life support? _____

   Certification expires: _____.

2. Certified in advanced cardiac life support? _____

   Certification expires: _____.

3. Certified in advanced trauma life support? _____

   Certification expires: _____.

4. Certified in pediatric advanced life support? _____

   Certification expires: _____.

LIABILITY CLAIMS AND ADVERSE ACTION

If your answer to any of the following is “yes,” please provide full details on an attached separate sheet if this information has not previously been submitted to this medical staff.

1. Have there been any previously successful or any currently pending challenges to any of your licenses or registrations (State or district, Drug Enforcement Administration) or the voluntary relinquishment of licenses or registrations?

   YES: _____ NO: _____

2. Has your medical staff membership at another hospital been voluntarily or involuntarily terminated? Have your clinical privileges at another hospital been voluntarily or involuntarily limited, reduced, or lost?

   YES: _____ NO: _____

3. Are you currently or have you been involved in any professional liability actions?

   YES: _____ NO: _____

_____ _____
Signature Date

After review of the applicant's performance, in accordance with the medical staff bylaws and as summarized in the IHS Work Sheet for Reappointment to the Medical Staff, I do ___ do not ___ recommend reappointment to the _____ medical staff.

I do ___ do not ___ recommend renewal of clinical privileges as requested above.

_____ _____
Clinical Director Date

Comments:

_____

_____

_____

_____

I do ___ do not ___ recommend renewal of clinical privileges as requested above.

_____ _____
Service Unit Director Date

Comments:

_____

_____

_____

_____

Reappointment and privileges are ___ are not ___ approved.

_____ _____
Chair of the Governing Body Date

TO BE COMPLETED BY CLINICAL DIRECTOR OR DESIGNEE

WORKSHEET FOR REAPPOINTMENT TO THE MEDICAL STAFF OF:

_____ _____ _____
(Hospital/Health Center) (Town/City) (State)

Name of Applicant: _____

Note: Any "no" answer on items 1–14 and any "yes" answers on items 15–23 need to be explained fully on attached page(s).

Description	**Yes**	**No**
1. Is this applicant physically, mentally, and emotionally capable of performing the services required of a member of the medical staff and requested privileges?	☐	☐
2. Has this applicant consistently complied with the medical staff bylaws, rules, and regulations of this facility?	☐	☐
3. Has this applicant provided verification of current licensure?	☐	☐
4. Have favorable reports been received on this applicant's professional competence, clinical judgment, and personal character?	☐	☐
5. Are the privileges being sought the same as those currently granted?	☐	☐
6. Does this applicant relate and work well with other patient care staff?	☐	☐
7. Is this applicant readily available and responsive when needed?	☐	☐
8. Does this applicant regularly attend medical staff meetings?	☐	☐
9. Has this applicant shown willingness to serve on, or chair, appropriate committees when asked to do so?	☐	☐
10. When appointed to a committee, has this applicant served in the capacity to which appointed and attended meetings with appropriate regularity?	☐	☐
11. Has this applicant willingly participated in the quality assurance program and functions of this IHS facility?	☐	☐
12. Has this applicant been cooperative in observance of medical staff and hospital procedural rules?	☐	☐
13. Has this applicant been cooperative in compliance with established medical records requirements?	☐	☐
14. Has this applicant consistently completed medical records within prescribed time limits?	☐	☐
15. Have any adverse actions been initiated or any judgments rendered against this applicant or against the Federal Government on the basis of this applicant's patient care practices?	☐	☐
16. Has this applicant required counseling due to non-conformance with standards in his/her clinical practice or medical staff related activities?	☐	☐
17. Has any disciplinary action been taken against this applicant?	☐	☐
	☐	☐

Description	**Yes**	**No**
18. Has this applicant exercised any clinical privileges which had not been granted?		
19. Has there been any reduction or revocation of clinical privileges for this applicant?	☐	☐
20. Has there been any change in the physical, mental, or emotional health or condition in this applicant?	☐	☐
21. Has this applicant shown evidence of any alcohol or drug abuse or dependency?	☐	☐
22. Has this applicant had any treatment for alcohol or drug abuse or dependency?	☐	☐
23. Did the National Practitioner Data Bank query reveal any adverse information?	☐	☐
24. Relative to the review functions listed, how does this applicant's performance as a member of the patient care staff compare to the staff as a whole in numbers of problems attributed to his/her patient care practices?	☐	☐

	Fewer Than Average	More Than Average	Average	Does not Apply
a. Monitoring functions	☐	☐	☐	☐
b. Surgical case review	☐	☐	☐	☐
c. Pharmacy/therapeutics review	☐	☐	☐	☐
d. Medical records review	☐	☐	☐	☐
e. Blood usage review	☐	☐	☐	☐
f. Antibiotic usage review	☐	☐	☐	☐
g. Morbidity/mortality review	☐	☐	☐	☐
h. Emergency care review	☐	☐	☐	☐
i. Infection control	☐	☐	☐	☐
j. Utilization review	☐	☐	☐	☐
k. Incidence reports	☐	☐	☐	☐
l. QA committee reports	☐	☐	☐	☐

Quantify and comment on any "more than average" ratings.

_____

_____

_____

25. Information presented to the Medical Staff Executive Committee? Yes: __ No: _____ Date: _____

26. Comments of Medical Staff Executive Committee:

_____

_____

_____

_____

_____

_____

_____

27. Recommendation of the Medical Staff Executive Committee:

a. _____ Continue membership with privileges as requested, including requested modifications, if any.

b. _____ Continue membership with same privileges as previously granted. Changes requested by applicant denied.

c. _____ Continue membership with privileges modified as recommended by the Medical Staff Executive Committee. (Attach these recommendations.)

d. _____ Discontinue membership.

CERTIFICATION

I certify that the information provided herein is true and correct to the best of my knowledge.

_____ _____
Clinical Director Date