

CCQAS Agency Disclosure Notice Placeholder and Screenshots

All CCQAS users are presented with the below statement and warning banner upon login to the web based application. This statement and banner will be updated to include the Agency Disclosure Notice with the language displayed below in the red text box. Updates to this page require code change, which is costly and timely, and must be scheduled as part of the CCQAS sustainment vendor's future work. This change will be made when the OMB Control Number and Expiration Date has been finalized.

JCCQAS - Privacy Act ×

JCCQAS ****For Official Use Only (FOUO)****

PRIVACY Act Statement and Warnings

Before proceeding to the JCCQAS logon screen, users must acknowledge at the bottom of the page that they are aware of the Privacy Act Statements and Warnings associated with using this computer system for the Department of Defense (DoD).

DoD PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the Joint Centralized Credentials Quality Assurance System (JCCQAS) and how it will be used.
AUTHORITY: 10 U.S.C. 1102, Confidentiality of medical quality assurance records; qualified immunity for participants; 42 U.S.C. Chapter 117, Encouraging good faith professional review activities; DoD Instruction 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS); DoD Regulation 6025.13-R, Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation; and E.O. 9397 (SSN), as amended.
PURPOSE: To obtain information necessary to credential a health care provider and determine whether that individual should have privileges to work, or continue working, in a military treatment facility (MTF) or otherwise within the Military Health System (MHS), including information on malpractice claims and adverse privilege actions. Information is also collected to report malpractice claims or adverse privilege actions filed against a health care provider in connection with a service performed at an MTF or within the MHS.
ROUTINE USES: Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. Information may be used and disclosed in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD "Blanket Routine Uses" published at: <http://dpcid.defense.gov/privacy/somsindex/blanketroutineuses.aspx>. Collected information may be shared with government boards, agencies, professional societies, or organizations if needed to license or monitor professional standards of health care practitioners. It may be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges, or already privileged, regardless of whether the practitioner is still privileged at an MTF. Information may also be used to conduct trend analysis for medical quality assurance programs.
DISCLOSURE: Voluntary. However, failure to provide information may result in an individual's ineligibility to serve at an MTF or within the MHS.

DoD 1102 PROTECTED STATUS

JCCQAS includes Sensitive but Unclassified (SBU) information that is subject to the Privacy Act of 1974, as amended. Consequently, copying, printing, or distributing data from JCCQAS to support administrative functions is authorized by, and subject to the limitations of, DoD Regulation 5400.11-R, Department of Defense Privacy Program. Certain information contained within JCCQAS is accessible under the Freedom of Information Act. The use and disclosure of some information in JCCQAS is protected from legal discovery under 10 U.S.C. 1102. No other distribution is permitted without the express written permission of the TriCare Management Activity Functional Proponent or Service JCCQAS Representatives, who will coordinate with appropriate legal counsel prior to rendering an opinion regarding release of information.

DoD HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WARNING

This system contains protected health information as defined in the Health Information Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule (45 CFR Parts 160 and 164). DoD's implementation of the HIPAA Privacy Rule is in DoD 6025.18-R, DoD Health Information Privacy Regulation. The HIPAA Privacy Rule and DoD 6025.18-R apply to protected health information and may place additional procedural requirements on uses and disclosures of such information beyond those found in the Privacy Act or mentioned elsewhere in this notice. This information may only be used and/or disclosed in strict conformance with that authority. The MHS is required to, and will, appropriately sanction individuals who fail to comply with its privacy policies and procedures.

Yes, I understand the contents of the above Privacy Act Statements and Warnings.

No, I do not understand the contents of the above Privacy Act Statements and Warnings.

AGENCY DISCLOSURE NOTICE

OMB CONTROL NUMBER: [XXXX-XXXX]
OMB EXPIRATION DATE: [MM/DD/YYYY]

The public reporting burden for this collection of information, [Insert OMB Control Number], is estimated to average four hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

The following screenshots depict the data fields within CCQAS where information is collected for a health care provider.

Once a Military Health System (MHS) health care provider has gained access to CCQAS, a new Credentials record is generated. A single Credentials record is maintained in CCQAS for each health care provider over the entirety of his or her service to the MHS and is updated overtime to reflect the provider’s qualifications to provide clinical care. This information collection occurs by manual entry into CCQAS. Health care providers supply demographic information, licensure, certification, education and training, work history, professional specialties, and health status in a Credentials record.

Additionally, documents are uploaded and attached to a provider’s Credentials record to be validated by a Credentials manager. For certain provider types that require privileges to deliver care, completion of an electronic application (E-application) occurs (reference pages 41-44 here within). The Credentials record and electronic application provide the basis for the MHS’ credentialing and privileging processes.

The screenshot shows the JCCQAS interface with a 'Work List' window. The window title is 'Work List' and it includes a 'Status' dropdown menu set to 'Open Tasks'. Below the dropdown is a table with the following columns: Urgent, Task, App Type, Facility, Credentialer, Credentialer Phone, Task Start Date, and Task Complete Date. A single row is displayed with the following data: Urgent: No, Task: Complete Application (Civilian), App Type: New E-App, Facility: WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), Credentialer: (empty), Credentialer Phone: (empty), Task Start Date: 03/17/2021, Task Complete Date: (empty).

Urgent	Task	App Type	Facility	Credentialer	Credentialer Phone	Task Start Date	Task Complete Date
No	Complete Application (Civilian)	New E-App	WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC)			03/17/2021	

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Instructions Help

- Your application consists of several sections listed to the left of this screen. With the exception of the E-signature which is the final step for submission of this application, the sections can be completed in any order.
- You must click on the <Save> button wherever available so that you do not lose any information you have entered. If you have to leave the application before completing it, all saved information will be available when you return to complete the application.
- As you complete each section, the icon next to that section will change as designated in the legend below these instructions. Complete all required fields in every section to avoid delays in processing your application. Section(s) that are indicated as required, that are not marked as complete must be completed in order to sign and submit the E-application.
- Once your E-application is completed, signed and submitted, the navigation bar sections are locked to reflect that the sections are complete, and you cannot edit the record unless it is reopened by the Credentialed. You will be notified if additional information is needed.
- All information you provide will be reviewed, verified and acted upon accordingly by reviewing and approving authorities.

- * Section required for E-Signature.
- This section requires review.
- Section has not been completed.
- Section has been completed/reviewed.
- 🔒 Section has been locked for the review/approval process.
- ⚠ Section has been unlocked for updates.

Need Help? Contact your Credentials Office

Next Section

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Profile Help

Information: If known under another name (i.e. maiden name), please complete the Former Names section. Please verify that any pre-populated information below is correct. Please contact the **Credentials Office** if you need assistance or information needs to be updated in a disabled field.

Provider

Last Name * FEBARMYIAVA First Name * LEANNE Middle Initial Name

Title Suffix Gender * Female

Date of Birth * 06/06/1980 Person ID Type SSN Person ID Number 601323589

US Citizenship/Visa * US - United States of America Marital Status NPI * Source DMHRSI

Birth City * Birth State * Birth Country *

Occupation Physician Occupation Category Licensed Independent Practitioner

Civilian

Grade Role * Accession *

Former Names

Title	Former Last Name	Former First Name	Former Middle Initial Name	Suffix	Date Name Changed	NPOB
No data available in table						

Add

Comments

Save Next Section

- Navigation
- Instructions
 - Profile *
 - Position ***
 - Identification *
 - Contact Information *
 - License *
 - Certification/Registration
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - E-Signature *
 - Documents
 - Application Summary
 - Comments
 - Application Packet (PDF)

Position Help

Provider Category * Duty Section Duty Phone

Date Reported to Current Assignment Projected Rotation/PCS Date

Privileging

Are you requesting privileges at this time? * No Yes

Type of Privileges Requested Type of Appointment Requested

Information! The E-app allows for privileges to be requested at multiple Facilities/UICs. Select one or more Facilities/UICs from the list below.

Facility/UIC	Name	Location	Request Admitting Privileges?	Facility Type
<input checked="" type="checkbox"/>	WZDNAA	BROOKE ARMY MED CTR (Privileged Providers UIC)	<input type="checkbox"/>	Parent

Save Next Section

- Navigation
- Instructions
 - Profile *
 - Position *
 - Identification ***
 - Contact Information *
 - License *
 - Certification/Registration
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
 - Documents
 - Application Summary
 - Comments
 - Application Packet (PDF)

Identification Help

Identification Type	Identification Number	State
<input type="text" value="Social Security Number"/>	601323589	N/A

Add Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification ***
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Identification Help

Identification Type *	Identification Number *	State *
U.S. Drivers License	1111111	WA - Washington

Navigation

Instructions

Profile *

Position *

Identification *

Contact Information *

Address

Email

Phone

License *

Certification/Registration *

Board Certification

DEA

State CDS

Education/Training *

Specialty *

Academic Affiliations

Organizational Memberships

Continuing Education

Contingency/Additional Training

Practice History *

Health Status *

References *

Work History *

Malpractice Insurance *

Privileges (WZDNAA) *

E-Signature *

Documents

Application Summary

Comments

Application Packet (PDF)

Information! At least one address of type Home, designated as Primary, is required to e-sign this application.

Address			Help
Address Type	Full Address	Primary	
Location of Birth	Test, WA US	No	
Add Next Section			

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information ***
 - Address**
 - Email
 - Phone
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Address Help

Information! At least one address of type Home, designated as Primary, is required to e-sign this application.

Address Type * **Primary** Yes No

Address 1 *

Address 2

Address 3

City/Town *

State * **Country ***

Province **Postal Code ***

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information ***
 - Address
 - Email**
 - Phone
- License *
- Certification/Registration *
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Email		Help
Email Address		Primary Email
learninc.spinale@asmr.com		Yes
<input type="button" value="Add"/>		<input type="button" value="Next Section"/>

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
 - Address
 - Email**
 - Phone
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Email Help

Information! At least one email address, designated as Primary, is required to e-sign this application.

Email *

Primary Email

Yes No

Save Close

- Navigation
- Instructions
 - Profile *
 - Position *
 - Identification *
 - Contact Information ***
 - Address
 - Email
 - Phone**
 - License *
 - Certification/Registration
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (W2DNAA) *
 - E-Signature *
 - Documents
 - Application Summary
 - Comments
 - Application Packet (PDF)

Phone			Help
Phone Number	Phone Type	Primary	
1234567	Home	Yes	
			Add Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
 - Address
 - Email
 - Phone
- License *
- Certification/Registration <
- Board Certification
- DEA
- State CDS
- Education/Training * <
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) * <
- E-Signature *
- Documents <
- Application Summary
- Comments
- Application Packet (PDF)

Add Phone Help

Information! At least one phone (Voice), designated as Primary, is required to e-sign this application.

Phone Type *

Phone Number *

Primary Phone
 Yes No

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License ***
 - State
 - Unlicensed
- Certification/Registration *
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

State License							Hide History Help
License Number	State	Field	License Status	Original Issue Date	Expiration Date	Status	
No data available in table							
Add Next Section							

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License ***
 - State
 - Unlicensed
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add State License

Help

Information: To expedite the processing of your application, you must enter all previously and currently held licenses. State and National certification/registrations should be entered in the Certification/Registration section of this application. Medical and Dental Board certifications should be entered under the 'Board Certification' section of this application.

License Number *	<input type="text"/>	State *	<input type="text"/>
Field *	<input type="text"/> Sort	Original Issue Date *	<input type="text"/> <input type="checkbox"/> Original Issue Date Unavailable
Expiration Date *	<input type="text"/>	Expiration Indefinite	<input type="radio"/> Yes <input checked="" type="radio"/> No
Status *	<input type="text"/>	Remarks *	
<input type="text"/>			

Save Close

- Navigation
- Instructions
 - Profile *
 - Position *
 - Identification *
 - Contact Information *
 - License ***
 - State
 - Unlicensed
 - Certification/Registration
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
 - Documents
 - Application Summary
 - Comments
 - Application Packet (PDF)

Unlicensed Information Help

Unlicensed Reason *

Available States

 Add

Licensure States

Abbreviation	State
No data available in table	

Remarks

Historical Records

Status	Date/Time Updated	Reason	State	Remarks
No data available in table				

Save Next Section

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration**
 - State**
 - National
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
 - Application Summary
 - Comments
 - Application Packet (PDF)

State Certification/Registration							Hide History Help	
Type	State	Number	Field	Cert/Reg Status	Issue Date	Expiration Date	Status	
No data available in table								
				Add	Next Section			

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration**
 - State**
 - National
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add State Certification/Registration Help

Information: To expedite the processing of your application, you must enter all previously and currently held state registrations and/or state certifications. Any state licenses must be entered in the License section.

Type *	Number *	State *
<input type="text"/>	<input type="text"/>	<input type="text"/>
Field *	<input type="text"/>	
<input type="text"/>	<input type="text"/>	
Issue Date	Expiration Date *	<input type="checkbox"/> Expiration Indefinite
<input type="text"/>	<input type="text"/>	
Status *	<input type="text"/>	
<input type="text"/>		
Remarks *	<input type="text"/>	

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration**
 - State
 - National**
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

National Certification/Registration Hide History | Help

Type	Number	Field	Specialty	Cert/Reg Status	Issue Date	Expiration Date	Status
No data available in table							
Add Next Section							

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Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation <

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
 - State
 - National**
 - Board Certification
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
- Documents <
- Application Summary
- Comments
- Application Packet (PDF)

Add National Certification/Registration Help

Information: To expedite the processing of your application, you must enter all previously and currently held registrations and/or certifications. Medical and Dental Board certifications should be entered under the 'Board Certification' section on the Navigation Menu of this application.

Type * Number * Field * Sort

Specialty * Agency *

Status * Issue Date Expiration Date *

Remarks *

Save Close

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation <

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration <
- Board Certification**
 - DEA
 - State CDS
 - Education/Training *
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
- Documents <
- Application Summary
- Comments
- Application Packet (PDF)

Information: Please ensure that all Board Certifications for your specialties and sub-specialties have been entered.

Board Certification Hide History | Help

Specialty	Sub Specialty	Original Certification Date	Expiration Date	Status
No data available in table				

Add Next Section

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation <

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration *
- Board Certification**
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents <
- Application Summary
- Comments
- Application Packet (PDF)

Add Board Certification Help

Information! Specialty boards may require ongoing professional competency activities, such as CME, in order for a provider to maintain their board certification. This requirement is referred to as "Maintenance of Certification" (MOC).

Practitioner Type * Specialty * Subspecialty *

Agency/Board * Find

Certification Number Original Certification Date *

Expiration Date Expiration Indefinite No Yes

MOC Participating Yes No N/A Meeting MOC Requirement Yes No N/A

Latest Recertification Date

MOC Reverification Date

Remarks

Save Close

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Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation <

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration *
- Board Certification
- DEA**
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents <
- Application Summary
- Comments
- Application Packet (PDF)

Drug Enforcement Administration (DEA) Hide History | Help

DEA Number	Type	Issue Date	Expiration Date	Status
No data available in table				

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA**
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add DEA Help

DEA Number * Type *

Issue Date * Expiration Date *

mm/dd/yyyy mm/dd/yyyy Expiration Indefinite

DEA Schedules

Remarks

Save Close

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS**
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

State CDS Hide History | Help

State CDS Number	State	Expiration Date	Status
No data available in table			

Add Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS**
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add State CDS Help

State CDS Number *	State *	Issue Date
<input type="text"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>
Expiration Date *		
<input type="text" value="mm/dd/yyyy"/>		
Remarks		
<input type="text"/>		

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training ***
 - Professional Education**
 - ECFMG
 - Post Graduate Training
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Professional Education

Hide History | Help

Degree	Type	Qualifying	Institution Name	Attended From	Attended To	Graduation Date	Completed	Status
No data available in table								
Add Next Section								

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
 - Professional Education
 - ECFMG
 - Post Graduate Training
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Professional Education

Help

Information: You must enter all associated professional education information. One professional education record must be indicated as the education qualifying you to work in your profession. If an International Graduate but NOT Fifth Pathway, please add your ECFMG or Foreign Graduate Certification information to the ECFMG or Foreign Graduate section of this application.

Type * Qualifying

International Graduate Fifth Pathway

Degree *

Institution Name * Check here if institution Not found

Address 1 **Address 2** **City ***

State * **Postal Code *** **Country**

Attended From * **Attended To ***

Completed * **Graduation Date**

Remarks

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training ***
 - Professional Education
 - ECFMG**
 - Post Graduate Training
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Information If you are an International Graduate, and hold a certification recognizing your education, please add your certification information.
 ECFMG - Educational Council for Foreign Medical Graduates
 Fifth Pathway Graduate Information should be entered in the Post Graduate Training section. If Fifth Pathway, ensure that the Fifth Pathway checkbox is selected on the Professional Education page.

ECFMG				Hide History Help
Certificate Number	Certification Date	Expiration Date	Status	
No data available in table				
Add				Next Section

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
 - Professional Education
 - ECFMG**
 - Post Graduate Training
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add ECFMG Help

Certificate Number *

Certification is valid through *
 Indefinite Expires (on Date)

Date Taken **Certification Date *** **Expiration Date**

Remarks

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training ***
 - Professional Education
 - ECFMG
 - Post Graduate Training**
 - Specialty *
 - Academic Affiliations
 - Organizational Memberships
 - Continuing Education
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (W2DNAA) *
 - E-Signature *
 - Documents
- Application Summary
- Comments
- Application Packet (PDF)

Post Graduate Training								Hide History Help	
Field of Study	Training Type	Institution	Attended From	Attended To	Completion Date	Completed	Status		
No data available in table									
Add Next Section									

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training ***
 - Professional Education
 - ECFMG
 - Post Graduate Training**
 - Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Post Graduate Training

Help

Type *	Field Of Study *	
<input type="text"/>	<input type="text"/>	
Institution Name *		
<input type="text"/>	<input type="button" value="USUHS"/> <input type="button" value="Find"/>	
<input type="checkbox"/> Check here if institution NOT found		
Address 1	Address 2	City *
<input type="text"/>	<input type="text"/>	<input type="text"/>
State *	Postal Code *	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>
Attended From *	Attended To	
<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>	
Completed *	Completion Date	
<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	
Remarks		
<input type="text"/>		
<input type="button" value="Save"/> <input type="button" value="Close"/>		

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty ***
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Specialty				Hide History Help
Specialty	SubSpecialty	Specialty Level	Status	
▼ Allergy & Immunology	Allergy	Board Certified	Un-Submitted	

Add Next Section

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty ***
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Specialty Help

Information: Please ensure that all of your specialties and sub-specialties have been entered. If you are board certified in any of your specialties, please enter them in the Board Certification section.

Practitioner Type * Specialty * SubSpecialty *

Level *

Remarks

Save Close

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations**
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Academic Affiliation

Name	Start Date	End Date	Status
No data available in table			

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations**
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Academic Affiliation

Military Facility Civilian Facility

Institution Name * USUHS Find Position *

Address 1 Address 2 City/Town

State Postal Code Phone

Start Date End Date

POC Name POC Phone POC Email

Save Close

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships**
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Organizational Membership Hide History | Help

Name	Start Date	End Date	Status
No data available in table			

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships**
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Organizational Membership Help

Military Facility Civilian Facility

Institution Name * USUHS Find Position *

Address 1 Address 2 City/Town

State Postal Code Phone

Membership Dates From Membership End Date Lifetime Member

POC Name POC Phone POC Email

Save Close

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education**
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Continuing Education Show History | Help

Course Type	Credit Hours	Course Number/Sponsor	Course Title	Started	Completed	Status
No data available in table						

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education**
 - Contingency/Additional Training
 - Practice History *
 - Health Status *
 - References *
 - Work History *
 - Malpractice Insurance *
 - Privileges (WZDNAA) *
 - E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Continuing Education Help

Type * Course Title Training Location

Start Date Completion Date Course No./Sponsor

Credit Category Credits Speaker

Remarks

Save Close

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training**
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Type	Completion Date	Expiration Date	Instructor	Status
No data available in table				

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training**
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Contingency/Additional Training Help

Type * Expiration Date *

Check here if you are an instructor

Remarks

Save Close

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History ***
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Information! A Practice History record must be added in order to complete the application.

Practice History		Hide History Help
Date/Time Submitted	Status	
No data available in table		
		Add Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration *
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History ***
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Practice History Questionnaire

Help

Information! You must select a response to each of the Practice History questions. If you answer 'Yes' to any of the questions, you must enter an explanation in the 'Comments' box.

Questions

1. On a voluntary or involuntary basis, has/have any staff appointment(s) ever been, or is/are in the process of being denied, terminated, discharged, revoked, suspended, reduced, limited, restricted, not renewed, withdrawn, or relinquished to avoid disciplinary or adverse privileging action? Yes No [Comments](#)
2. On either a voluntary or involuntary basis, have your clinical privileges ever been, or are they in the process of being denied, revoked, suspended, reduced, limited, restricted, not renewed, withdrawn, or relinquished? Yes No [Comments](#)
3. Have you ever been notified that the quality of the care you provided is being reviewed for an administrative claim for Damage, Injury, or Death, or a civil tort lawsuit filed concerning the healthcare provided to a patient? If YES, then in the comments section identify each claim/suit. If you are not sure whether a claim/suit has been filed, contact your local Risk Manager or attorney for assistance. Yes No [Comments](#)
4. Has an administrative claim or civil tort lawsuit concerning the healthcare you provided to a patient ever been settled on your behalf? If YES, then in the comments section identify each claim/suit that was settled. If you are not sure whether a claim/suit has been settled, contact your local Risk Manager or attorney for assistance. Yes No [Comments](#)
5. Have you ever been convicted of, pled guilty to, or pled nolo contendere to a crime? If YES, then please identify it in the comments section, even if you received alternative sentencing such as probation or deferred adjudication. Yes No [Comments](#)
6. Have you ever been charged, in either a civilian court or under the Uniform Code of Military Justice, with assault, battery, a violent crime, a sexual offense, a drug or alcohol related offense, abuse or neglect, or any offense involving a child? If YES, then please identify it in the comments section. Yes No [Comments](#)
7. Do you currently have charges pending for any violation of law? If YES, please provide a full explanation of the circumstances. Yes No [Comments](#)
8. Have you ever resigned or retired from a clinical position after being notified you would be disciplined or discharged, that you would be the subject of an investigation, or after questions about your clinical competence were raised and not resolved? Yes No [Comments](#)
9. Has your license/certification/registration to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation, or any condition or limitation by any state? Yes No [Comments](#)
10. Have you ever received a reprimand or been fined by any state that issues your professional license/certification/registration? Yes No [Comments](#)
11. Is there currently pending or has your Federal DEA and/or DPS Controlled Substances Certificate or authorization ever been denied, suspended, revoked, or are any challenges or investigations pending? Yes No [Comments](#)
12. Has your participation in Medicare, Medicaid, or any other federal or state governmental healthcare program ever been, or is in the process of being—either on a voluntary or involuntary basis—denied, revoked, suspended, reduced, limited, restricted, withdrawn, or relinquished while under investigation? Yes No [Comments](#)
13. Has your participation in Medicare/Medicaid or any other federal or state government program been investigated or subject of a conviction for making or using false, fictitious, or fraudulent statements, representations, writings or documents, regarding a material fact in connection with the delivery of, or payment for healthcare benefits, item or services that would be in violation of the Criminal False Claims Act? Yes No [Comments](#)
14. Have you ever been investigated for alleged violation of the federal Anti-Kickback Statute concerning an offer, payment, solicitation or receipt of money, property or remuneration to induce or reward the referral of patients or healthcare services payable by a government health care program? Yes No [Comments](#)
15. Have you ever been investigated for violations involving the Physician Self-Referral law, commonly known as Stark law, regarding referrals for health services payable by Medicare to an entity with which you (or an immediate family member) had a financial relationship (ownership, investment, or compensation)? Yes No [Comments](#)
16. Is there currently pending or has there been on a voluntary or involuntary basis: a denial, revocation, suspension or non-renewal of your ECFMG Certification or Foreign Graduate Certification? Yes No [Comments](#)
17. Is there currently pending or has there been on a voluntary or involuntary basis a denial, revocation, suspension, reduction, limitation, restriction, non-renewal, or relinquishment either while under investigation or in lieu of disciplinary action, of your participation or membership in a Healthcare Organization (PPO, MCO, etc.) or Professional Society? Yes No [Comments](#)
18. Has your faculty membership in any professional school been removed or subject to disciplinary action? Yes No [Comments](#)
19. Have you ever been denied professional insurance, or has your policy ever been cancelled? Yes No [Comments](#)
20. Are you currently in default on repayments of scholarship obligations or loans in connection with health professions education made or secured in whole or in part by the government? Yes No [Comments](#)

Save Close

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status ***
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Information! A Health Status record must be added in order to complete the application.

Health Status Hide History | Help

Date/Time Submitted	Status
No data available in table	

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status ***
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Health Status Questionnaire Help

Information! You must select a response to each of the Health Status questions. If you answer 'Yes' to any of the questions, you must enter an explanation in the 'Comments' box.

Questions

1. Do you currently have a physical or mental impairment which might interfere with your ability to perform the procedures and essential functions of the position for which you have applied or requested clinical privileges, with or without accommodation, according to accepted standards of professional performance and without posing a direct threat to other staff or patients? Yes No [Comments](#)
2. Are you currently taking any medications that may interfere with your ability to perform the procedures and essential functions of the position for which you have applied or requested clinical privileges, with or without accommodation, according to accepted standards of professional performance and without posing a direct threat to other staff or patients? Yes No [Comments](#)
3. Do you have any reason to believe that you could pose a risk to the safety or well-being of your patients? Yes No [Comments](#)
4. Are you currently engaged in the illegal use of drugs? "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, and includes unlawful use of prescription controlled substances? Yes No [Comments](#)
5. Are you currently under treatment for an alcohol or drug related condition? Yes No [Comments](#)

Save Close

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References ***
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Information: Please ensure that you have added at least 2 current references. At least one phone number, email or address is required for each reference.

Reference	Current	Name	Title/Position	Address 1	City	State	Postal Code	Status
No data available in table								

Add Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References ***
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Reference Help

Information: Please ensure that you have added at least 2 current references. At least one phone number, email or address is required for each reference.

Reference

Current *
 No Yes

Reference

Title **Name *** **Business/Occupation**

Title/Position *

Address

Address 1 * **Address 2** **Address 3**

Address 4 **City *** **Province**

State * **Postal Code *** **Country**

Contact

Phone * **Fax** **Email ***

Save Close

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History ***
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Type	Facility/UIC	Facility Name	MIL/CIV	Provider Type	Start Date	End Date	Status
Assignment	WZDNAA	BROOKE ARMY MED CTR (Privileged Providers UIC) #	CIV	CNT - Contractor	03/17/2021		
GAP		Reason:			06/30/2018	03/17/2021	
Residency		Uniformed Services University of Health Sciences #			07/01/2016	06/30/2018	Un-Submitted
GAP		Reason:			05/31/2016	07/01/2016	
Qualifying Degree		Uniformed Services University of Health Sciences #		ADS - Active Duty Staff (non Training)	09/01/2012	05/31/2016	Un-Submitted

Add Work History Next Section

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My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History ***
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Gap Explanation - 05/31/2016 - 07/01/2016 Help

Information! If this gap is due to employment please add a work history record on the work history listing page. If the gap is related to clinical education or post graduate training please add a record in the Professional Education or Post Graduate Training listing page.

Reason *

Comment

Save Close

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History ***
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Work History Help

Assignment / Employment

Information: Selecting a Facility/UIC with the search function will populate Facility Name and applicable information in the Assignment/Employment Business Address section.

Employment Type *
 Military Civilian

Assignment Type
 Off-duty Employment

Facility Name *

Start Date *

End Date *

Current

Reason for Discontinuance *

Provider Type

Specialty

Sub-Specialty

Institution/Organization
 USUHS

Appointment

Position Title

Appointment Type

Staff Appointment Date

Staff Appointment Expiration Date

Clinical Support Staff (CSS)
 No Yes

Do you currently hold privileges at this institution? *
 No Yes

Patient Care Hours per Week

Assignment/Employment Business Address

Address 1 *

Address 2

City/Town *

State *

Country

Province

Postal Code *

Phone

POC Name

POC Phone

POC Email

Remarks

Malpractice Insurance

Federal Torts Claims Act
 No Yes

No malpractice insurance items found

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance ***
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Malpractice Insurance Help

Information! Select 'Yes' if you are covered under the Federal Torts Claims Act.

Do you have malpractice insurance?

Yes
 No

If no, please enter comments

Save Next Section

JCCQAS *****For Official Use Only (FOUO)*****

My Applications Help - Provider

Provider Application (New E-App) - WZDNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance ***
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Information! Enter all currently and previously held malpractice insurance policies. If you are covered under the Federal Torts Claims Act please add a record and indicate the 'Insurance/Contractor' as Federal Torts Claims Act.

Malpractice Insurance Hide History | Help

Insurance/Contractor	Policy Number	Expires	Address 1	Address 2	City	State	Postal Code	Status
No data available in table								

Add Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance ***
- Privileges (W2DNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Add Malpractice Insurance Help

Insurance/Contractor Name *	Policy Number	Policy Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>
Address 1	Address 2	<input type="checkbox"/> Current Policy
<input type="text"/>	<input type="text"/>	
City	State	Postal Code
<input type="text"/>	<input type="text" value="▼"/>	<input type="text"/>

- Navigation
- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration *
- Board Certification
- DEA
- State CDR
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDAAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Privilege Category (WZDAAA - BROOKE ARMY MED CTR (Privileged Providers LIC)) Help

Select all privilege categories that apply, and then click Save. Individual privilege items may be selected on the Privileges form.

Provider Category: Physician	Type	
<input type="checkbox"/> Adolescent Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Aerospace Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Air Reserve Components (UTA) - Physician	Core/Supplemental	Itemized
<input type="checkbox"/> Allergy and Immunology	Core/Supplemental	Itemized
<input type="checkbox"/> Anesthesiology	Core/Supplemental	Itemized
<input type="checkbox"/> Cardiology	Core/Supplemental	Itemized
<input type="checkbox"/> Cardiothoracic Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Child Abuse/Forensic Pediatrics	Core/Supplemental	Itemized
<input type="checkbox"/> Clinical Cardiac Electrophysiology	Core/Supplemental	Itemized
<input type="checkbox"/> Critical Care - Internal Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Critical Care-Anesthesia	Core/Supplemental	Itemized
<input type="checkbox"/> Critical Care-Emergency Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Critical Care-Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Dermatology	Core/Supplemental	Itemized
<input type="checkbox"/> Developmental-Behavioral Pediatrics	Core/Supplemental	Itemized
<input type="checkbox"/> Diagnostic Radiology	Core/Supplemental	Itemized
<input type="checkbox"/> Emergency Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Endocrinology	Core/Supplemental	Itemized
<input type="checkbox"/> Family Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Flight Surgeon	Core/Supplemental	Itemized
<input type="checkbox"/> Gastroenterology	Core/Supplemental	Itemized
<input type="checkbox"/> General Medical Officer	Core/Supplemental	Itemized
<input type="checkbox"/> General Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> General Thoracic Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Genetics	Core/Supplemental	Itemized
<input type="checkbox"/> Hematology - Oncology	Core/Supplemental	Itemized
<input type="checkbox"/> Infectious Disease	Core/Supplemental	Itemized
<input type="checkbox"/> Internal Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Interventional Cardiology	Core/Supplemental	Itemized
<input type="checkbox"/> Interventional Radiology	Core/Supplemental	Itemized
<input type="checkbox"/> Neonatology	Core/Supplemental	Itemized
<input type="checkbox"/> Nephrology	Core/Supplemental	Itemized
<input type="checkbox"/> Neurology	Core/Supplemental	Itemized
<input type="checkbox"/> Neurosurgery	Core/Supplemental	Itemized
<input type="checkbox"/> Nuclear Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> OB/GYN - Female Pelvic Medicine and Reconstructive Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> OB/GYN - Maternal Fetal Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> OB/GYN - Minimally Invasive Gynecological Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> OB/GYN - Oncology	Core/Supplemental	Itemized
<input type="checkbox"/> OB/GYN - Reproductive endocrinology and infertility	Core/Supplemental	Itemized
<input type="checkbox"/> Obstetrics and Gynecology	Core/Supplemental	Itemized
<input type="checkbox"/> Occupational Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Ophthalmology	Core/Supplemental	Itemized
<input type="checkbox"/> Orthopedic Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Otolaryngology	Core/Supplemental	Itemized
<input type="checkbox"/> Pathology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Cardiology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Critical Care	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Endocrine, Diabetes and Metabolism	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Gastroenterology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Hematology/Oncology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Infectious Diseases	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Medical Genetics	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Nephrology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Neurology	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Pulmonary Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatric Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Pediatrics	Core/Supplemental	Itemized
<input type="checkbox"/> Physical Medicine and Rehabilitation	Core/Supplemental	Itemized
<input type="checkbox"/> Physician Acupuncturist	Core/Supplemental	Itemized
<input type="checkbox"/> Plastic Surgery	Core/Supplemental	Itemized
<input type="checkbox"/> Preventive Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Psychiatry	Core/Supplemental	Itemized
<input type="checkbox"/> Pulmonary Disease	Core/Supplemental	Itemized
<input type="checkbox"/> Radiation Oncology	Core/Supplemental	Itemized
<input type="checkbox"/> Registered Nurse First Assistant	Core/Supplemental	Itemized
<input type="checkbox"/> Rheumatology	Core/Supplemental	Itemized
<input type="checkbox"/> Sleep Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Sports Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Undersea Medicine	Core/Supplemental	Itemized
<input type="checkbox"/> Urology	Core/Supplemental	Itemized
<input type="checkbox"/> Vascular Surgery	Core/Supplemental	Itemized

Save Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration *
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) ***
 - Categories (WZDNAA)
 - Privileges (WZDNAA)
 - Age Groups (WZDNAA)
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Success! Privileges Category record has been saved

Privileges (WZDNAA) Help

Privilege Category: Allergy and Immunology
 Sort By: Entered Order
 Privilege Type: Itemized

Information Click the "Add Privilege" button to request additional privileges. The privilege will be added to the "OTHER" folder. Be sure to select your destinations for each category in the list above. For each category, after you have completed or reviewed your destinations, click "Save". To set all privileges of a section at once, click on the "Fully Competent", "With Supervision" or "Not Requested" column headers. Supervision required. (Unlicensed/uncertified or lacks current relevant clinical experience. ****ONLY USED FOR ARMY AND AIR FORCE**** Providers should request privileges based on education, training, current competency and ability to perform and should not consider any known facility limitations.

Allergy and Immunology

Version 1.0

Physicians requesting privileges in this subspecialty must also request privileges in their primary discipline as indicated/appropriate in accordance with Service Policy.

Scope

Privileges	Fully Competent	With Supervision	Not Requested	Facility Supported
(C) The scope of privileges in Allergy and Immunology includes the evaluation, diagnosis, consultation, management, and provision of therapy and treatment for patients presenting with hypersensitivity and immunologic conditions or disorders. This scope also includes the consultation, management, education, and provision of therapy and treatment for patients presenting for immunization healthcare including routine prevention, travel, education, military readiness and adverse events. Physicians may admit and may provide care to patients in the intensive care setting in accordance with MTF policies.	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported

Diagnosis and Management

Privileges	Fully Competent	With Supervision	Not Requested	Facility Supported
(C) Performance and interpretation of diagnostic testing for immediate hypersensitivity disease (skin testing, challenges)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Performance and interpretation of diagnostic testing for delayed hypersensitivity	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Performance and interpretation of diagnostic testing for reactive airway disease and asthma (e.g., spirometry with flow-volume loops, bronchodilator response, bronchoprovocation challenges)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Immunoglobulin therapy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Allergen immunotherapy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Immunomodulator therapy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Nasal Cytology	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported

Procedures

Privileges	Fully Competent	With Supervision	Not Requested	Facility Supported
(C) Drug and immunization challenges and/or desensitizations	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Autologous serum testing for autoimmune urticaria	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
Fiberoptic rhinolaryngoscopy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Exercise Challenge	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported
(C) Food Challenge	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Supported

Other (Facility- or provider-specific privileges only)

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature *
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

Age Groups (WZDNAA)

Help

Patients in Age Groups being treated?

- Check All
- Neonates (Birth-28 days)
- Young Adults (18-23 years)
- Infants (1-24 months)
- Adults (24-65 years)
- Children (2-12 years)
- Geriatrics (>65 years)
- Adolescents (13-17 years)

Save

Next Section

Navigation

- Instructions
- Profile *
- Position *
- Identification *
- Contact Information *
- License *
- Certification/Registration
- Board Certification
- DEA
- State CDS
- Education/Training *
- Specialty *
- Academic Affiliations
- Organizational Memberships
- Continuing Education
- Contingency/Additional Training
- Practice History *
- Health Status *
- References *
- Work History *
- Malpractice Insurance *
- Privileges (WZDNAA) *
- E-Signature ***
- Documents
- Application Summary
- Comments
- Application Packet (PDF)

E-Signature

Help

Information! You must select a response to each of the Attestation Statements. If you answer 'No' to any of the statements, you must enter an explanation in the 'Comments' box.

Attestation Statement

Your application cannot be submitted until you have signed it. This screen allows you to electronically 'sign' your application. I acknowledge I have been furnished with the current Medical Staff Bylaws for

BROOKE ARMY MED CTR (Privileged Providers UIC) (WZDNAA) and I hereby agree to abide by them.

I certify that (check appropriate box for each paragraph):

- I have been provided a copy or access to the professional staff policies, directives, procedures, and bylaws of the facility(s) and an opportunity to read those documents. I agree to comply with the professional staff policies, directives, procedures, and bylaws of the facility.

Yes No [Comments](#)
- I understand that my professional obligations can be compromised by financial conflicts of interest; therefore, I agree to avoid conflicts or seek guidance in their management.

Yes No [Comments](#)
- I will provide for the continuity of care to the patients assigned to me or arrange for transfer of care, as appropriate.

Yes No [Comments](#)
- I will notify my supervisor and the appropriate facility office responsible for authentication of practice credentials if my license, certification, or registration to practice or prescribe in the future becomes non-current, inactive, invalid, or restricted or there is any other change in the status of a credential.

Yes No [Comments](#)
- To my knowledge, I am not currently under investigation for the quality of the clinical care I provided in which substandard care, professional incompetence or professional misconduct has been alleged.

Yes No [Comments](#)
- I will notify the privileging authority and my chain of command, if different from privileging authority, of any change in my mental or physical condition that could limit my clinical ability or performance.

Yes No [Comments](#)
- I possess the credentials and current clinical competence to justify the granting of staff appointment with clinical privileges as requested.

Yes No [Comments](#)
- All information submitted by me in this application is accurate, complete and made in good faith, to the best of my knowledge and belief. I understand any false or incomplete information knowingly provided on or with this application may be grounds for not employing or accessing me, or for dismissing or releasing me if I am already employed or serving. I understand that knowingly providing false or incomplete information is punishable by fine or imprisonment under U.S. Code Title 18, Section 1001.

Yes No [Comments](#)

I authorize the inspection by

BROOKE ARMY MED CTR (Privileged Providers UIC) (WZDNAA) Its professional staff and/or lawful representatives of all records and documents, including health records in other treatment facilities that may be material to the evaluation of my professional qualifications. I consent to the release of any and all requested information about me to the inquiring facility or its lawful representatives. I release from liability all individuals or organizations who respond honestly and in good faith to inquiries authorized in paragraphs above.

I Agree with the Attestation Statement above

LEANNE FEBARMYJAVA

Comments

Text input area for comments.

I Agree Next Section