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://dpcld.defense.gov/privacy/sornsindex/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.

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

My Applications Help Provider

My Applications

Navigation

Work List

Applications

Documents

Work List Help

Status

Open Tasks

	Urgent	Task	App Type	Facility	Credentialer	Credentialer Phone	Task Start Date	Task Complete Date
	No	Complete Application (Civilian)	New E-App	W2DNAA, 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) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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- E-Signature *
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- Comments
- Application Packet (PDF)

Instructions

Help

1. 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.

2. 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.

3. 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.

4. 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 Credentialer. You will be notified if additional information is needed.

5. 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

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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

Martital 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	NPDB
No data available in table						

Add

Comments

Save Next Section

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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Position Help

Provider Category * Physician

Duty Section

Duty Phone

Date Reported to Current Assignment mm/dd/yyyy

Projected Rotation/PCS Date mm/dd/yyyy

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
☑	W2DNAA	BROOKE ARMY MED CTR (Privileged Providers UIC)	3551 ROGER BROOKE DRIVE, TX	☐	Parent

Save Next Section

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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Identification Help

	Identification Type	Identification Number	State
▾	Social Security Number	601323589	N/A

Add Next Section

JCCQAS

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

My Applications   Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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Add Identification

Help

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

Save   Close

JCCQAS

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

My Applications   Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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 *

US- United States

Province

Postal Code *

Save Close

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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Email Help

	Email Address	Primary Email
	leanne.spinale@asmr.com	Yes

Add Next Section

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

Close Application

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Phone

Help

	Phone Number	Phone Type	Primary
	1234567	Home	Yes

Add Next Section

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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

Save Close

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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 *

State *

Field * Sort

Original Issue Date * mm/dd/yyyy

Original Issue Date Unavailable

Expiration Date * mm/dd/yyyy

Expiration Indefinite
Yes No

Status *

Remarks *

Save Close

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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 *

Field *

Sort

Issue Date

mm/dd/yyyy

Expiration Date *

mm/dd/yyyy

Expiration Indefinite

Status *

Remarks *

Save Close

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help ▾ Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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 (mm/dd/yyyy) | Expiration Date * (mm/dd/yyyy)

Remarks *

Save | Close

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

My Applications Help ▾ Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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

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

My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston Close Application

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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 * Physician | Specialty * | Subspecialty *

Agency/Board * Find | Certifying Board

Certification Number | Original Certification Date * mm/dd/yyyy | Latest Recertification Date mm/dd/yyyy

Expiration Date mm/dd/yyyy | Expiration Indefinite ○ No ○ Yes | MOC Reverification Date mm/dd/yyyy

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

Remarks

Save Close

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My Applications Help Provider

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Drug Enforcement Administration (DEA) Hide History | Help

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

Add Next Section

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My Applications Help Provider

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Add DEA Help

DEA Number * Type *

Issue Date * mm/dd/yyyy Expiration Date * mm/dd/yyyy ☐ Expiration Indefinite

DEA Schedules

Remarks

Save Close

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My Applications Help Provider

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State CDS Hide History | Help

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

Add Next Section

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My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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Add State CDS Help

State CDS Number *

State *

Issue Date mm/dd/yyyy

Expiration Date * mm/dd/yyyy

Remarks

Save Close

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

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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

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

My Applications Help Provider

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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 * USUHS Find ☐ Check here if institution **Not** found

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

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

Attended From * mm/dd/yyyy **Attended To** * mm/dd/yyyy

Completed * **Graduation Date** mm/dd/yyyy

Remarks

Save Close

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

My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help Provider

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Add ECFMG Help

Certificate Number *
0

Certification is valid through *
○ Indefinite ○ Expires (on Date)

Date Taken
mm/dd/yyyy

Certification Date *
mm/dd/yyyy

Expiration Date
mm/dd/yyyy

Remarks

Save Close

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My Applications Help Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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

My Applications Help Provider

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Add Post Graduate Training Help

Type *

Field Of Study *

Institution Name * USUHS Find

Check here if institution **NOT** found

Address 1

Address 2

City *

State *

Postal Code *

Country

Attended From * mm/dd/yyyy

Attended To mm/dd/yyyy

Completed *

Completion Date mm/dd/yyyy

Remarks

Save Close

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My Applications Help▾ Provider

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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

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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

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Academic Affiliation — Hide History | Help

Name	Start Date	End Date	Status
No data available in table			

Add Next Section

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My Applications Help

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Add Academic Affiliation — Help

○ Military Facility ○ Civilian Facility

Institution Name * USUHS Find

Position *

Address 1

Address 2

City/Town

State

Postal Code

Phone

Start Date mm/dd/yyyy

End Date mm/dd/yyyy

POC Name

POC Phone

POC Email

Save Close

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My Applications Help Provider

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Organizational Membership — Hide History | Help

Name	Start Date	End Date	Status
No data available in table			

Add | Next Section

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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 (mm/dd/yyyy) | Membership End Date (mm/dd/yyyy) | ☐ Lifetime Member

POC Name | POC Phone | POC Email

Save | Close

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My Applications Help

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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

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Add Continuing Education — Help

Type *

Course Title

Training Location

Start Date: mm/dd/yyyy

Completion Date: mm/dd/yyyy

Course No./Sponsor

Credit Category

Credits

Speaker

Remarks

Save | Close

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

My Applications Help Provider

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Contingency/Additional Training Hide History | Help

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

Add Next Section

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My Applications Help Provider

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Add Contingency/Additional Training Help

Type *

Expiration Date *

mm/dd/yyyy

☐ Check here if you are an instructor

Remarks

Save Close

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

My Applications Help ▾ Provider

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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

JCCQAS

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

My Applications | Help | Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston | Close Application

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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

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My Applications Help

Provider

Provider Application (New E-App) - W2DNAA, BROOKE ARMY MED CTR (Privileged Providers UIC), JBSA, Fort Sam Houston

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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

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My Applications Help

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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

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My Applications Help▾ Provider

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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 — Hide History | Help

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

Add | Next Section

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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

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My Applications Help Provider

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Work History — Hide History | Help

Type	Facility/UIC	Facility Name	MIL/CIV	Provider Type	Start Date	End Date	Status
Assignment	W2DNAA	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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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

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My Applications Help Provider

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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/UIC [Find Facility/UIC]

Facility Name *

Start Date * mm/dd/yyyy

End Date * mm/dd/yyyy

☐ Current

Reason for Discontinuance *

Provider Type

Specialty

Sub-Specialty

Institution/Organization USUHS [Find]

Appointment

Position Title

Appointment Type

Staff Appointment Date mm/dd/yyyy

Staff Appointment Expiration Date mm/dd/yyyy

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

[Save] [Close]

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My Applications Help

Provider

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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

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My Applications Help

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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

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My Applications Help Provider

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Add Malpractice Insurance Help

Insurance/Contractor Name *

Policy Number

Policy Expiration Date mm/dd/yyyy

Address 1

Address 2

☐ **Current Policy**

City

State

Postal Code

Save Close

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Privilege Category (W2DNAA - BROOKE ARMY MED CTR (Privileged Providers UIC)) Help

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

Provider Category: Physician

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

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Success! Privileges Category record has been saved

Privileges (W2DNAA)

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 delineations for each category in the list above.
For each category, after you have completed or reviewed your delineations, 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 wth 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.	○	○	◉	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)	○	○	◉	Supported
	(C) Performance and interpretation of diagnostic testing for delayed hypersensitivity	○	○	◉	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)	○	○	◉	Supported
	(C) Immunoglobulin therapy	○	○	◉	Supported
	(C) Allergen immunotherapy	○	○	◉	Supported
	(C) Immunomodulator therapy	○	○	◉	Supported
	(C) Nasal Cytology	○	○	◉	Supported

Procedures:

	Privileges	Fully Competent	With Supervision	Not Requested	Facility Supported
	(C) Drug and immunization challenges and/or desensitizations	○	○	◉	Supported
	(C) Autologous serum testing for autoimmune urticaria	○	○	◉	Supported
	Fiberoptic rhinolaryngoscopy	○	○	◉	Supported
	(C) Exercise Challenge	○	○	◉	Supported
	(C) Food Challenge	○	○	◉	Supported

Other (Facility- or provider-specific privileges only):

Save | Add Privilege | Close | Next Section

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Age Groups (W2DNAA) Help

Patients in Age Groups being treated?

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

Save Next Section

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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) (W2DNAA)**

and I hereby agree to abide by them.

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

1. 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

2. 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

3. 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

4. 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

5. 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

6. 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

7. I possess the credentials and current clinical competence to justify the granting of staff appointment with clinical privileges as requested.

   ○ **Yes** ○ **No** Comments

8. 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) (W2DNAA)**

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 FEBARMYIAVA

Comments

I Agree Next Section