

**DELINEATION OF CLINICAL PRIVILEGES**

*(For use of this form, see AR 40-68; the proponent agency is OTSG.)*

1. NAME OF PROVIDER <i>(Last, First, MI)</i>	2. RANK/GRADE	3. FACILITY
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**INSTRUCTIONS:**  
PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED". Each category and/or individual privilege listed must be coded. For procedures listed, line through and initial any criteria/applications that do not apply. Your signature is required at the end of Section I. Once approved, any revisions or corrections to this list of privileges will require you to submit a new DA Form 5440.  
SUPERVISOR: Review each category and/or individual privilege coded by the provider and enter the appropriate approval code in the column marked "APPROVED". This serves as your recommendation to the commander who is the approval authority. Your overall recommendation and signature are required in Section II of this form.

PROVIDER CODES	APPROVAL CODES
1 - Fully competent to perform	1 - Approved as fully competent
2 - Modification requested <i>(Justification attached)</i>	2 - Modification required <i>(Justification noted)</i>
3 - Supervision requested	3 - Supervision required
4 - Not requested due to lack of expertise	4 - Not approved, insufficient expertise
5 - Not requested due to lack of facility support	5 - Not approved, insufficient facility support

**SECTION I - CLINICAL PRIVILEGES**

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COMMENTS

SIGNATURE OF PROVIDER

DATE (YYYYMMDD)

**SECTION II - SUPERVISOR'S RECOMMENDATION**

Approval as requested

Approval with Modifications *(Specify below)*

Disapproval *(Specify below)*

COMMENTS

DEPARTMENT/SERVICE CHIEF *(Typed name and title)*

SIGNATURE

DATE (YYYYMMDD)

**SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION**

Approval as requested

Approval with Modifications *(Specify below)*

Disapproval *(Specify below)*

COMMENTS

COMMITTEE CHAIRPERSON *(Name and rank)*

SIGNATURE

DATE (YYYYMMDD)