

EVALUATION OF PRIVILEGES - INTERNAL MEDICINE AND SUBSPECIALTY	PERIOD	DATE
For use of this form, see AR 40-68; the proponent agency is OTSG	FROM	TO

RATED BY	PRIVILEGES PERFORMED BY	TREATMENT FACILITY
TITLE		

PRIVILEGES	RECOMMENDATIONS BY DEPT./SVS. CHIEF				
Privileges evaluation will be based on thorough appraisals of clinical performance.	ACCEPT-ABLE	BORDER-LINE	UNACCEPT-ABLE	REQUIRES ADDL. EDUCATION	SELDOM EXER-CISED
CLINICAL AREAS <i>(Write I, II, III or IV to Indicate the Category or Privileges in Each Area That You Are Requesting Privileges.)</i>					
a. Allergy-Immunology					
b. Cardiology					
c. Dermatology					
d. Endocrine and metabolic diseases					
e. Gastroenterology					
f. Hematology					
g. Infectious disease					
h. Internal medicine					
i. Nephrology					
j. Pulmonary disease					
k. Rheumatology					
l. Oncology					
SPECIAL PROCEDURES <i>(Check the Procedures for Which Privileges are Requested and Attach a Statement Indicating Your Qualifications to Perform Each of Them.)</i>					
Special Studies, Invasive					
a. Arterial puncture and cannulation					
b. Angiography, cerebral					
c. Arteriography					
d. Arthrocentesis					
e. Bronchial brushing					
f. Bronchial lavage					
g. Bronchograms					
h. Bone marrow aspiration					
i. Cardiac Catherization					
j. Cardiac pacemaker <i>(Transvenous)</i>					
k. Cholangiography, percutaneous					
l. Cisternal Tap					
m. Hemodialysis					
n. Hemofiltration					
o. Lymphangiography					
p. Myelography					
q. Paracentesis, abdominal					
r. Pericardiocentesis					
s. Peritoneal dialysis					
t. Phlebography					