

BP-A601_APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF (PHYSICIAN)

**APPLICATION FOR APPOINTMENT TO THE
MEDICAL STAFF (PHYSICIAN)**
**U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS**

HEALTHCARE FACILITY		LOCATION			DATE	
1. IDENTIFYING INFORMATION	LAST NAME	FIRST NAME	INITIAL	BIRTHPLACE		DATE OF BIRTH
	OFFICE ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	TELEPHONE
	HOME ADDRESS	CITY	STATE	ZIP CODE	AREA CODE	TELEPHONE
	CITIZENSHIP			SOCIAL SECURITY NUMBER		
	PRACTICE LIMITED TO					
	OTHER MEDICAL INTERESTS IN PRACTICE, RESEARCH, ETC.					
	PRACTICING WITH WHOM AND NATURE OF AFFILIATION					
2. PREMEDICAL EDUCATION	COLLEGE OR UNIVERSITY			DEGREE		
	ADDRESS				DATE OF GRADUATION	
3. MEDICAL EDUCATION	MEDICAL SCHOOL			DEGREE		
	ADDRESS				DATE OF GRADUATION	
4. INTERNSHIP	HOSPITAL	ADDRESS				
	TYPE OF INTERNSHIP				DATES	
5. RESIDENCIES AND FELLOWSHIPS						
	ADDRESS OF INSTITUTION, SPECIALTY AND DATES					

11. LICENSE	MEDICAL LICENSE (NAME OF STATE AND COUNTY)	DATE	LICENSE NO.
	MEDICAL LICENSE (NAME OF STATE AND COUNTY)	DATE	LICENSE NO.
	MEDICAL LICENSE (NAME OF STATE AND COUNTY)	DATE	LICENSE NO.

12. PROFESSIONAL REFERENCES

IF POSSIBLE, PROVIDE AT LEAST THE NAMES OF TWO MEMBERS OF THE MEDICAL STAFF AT YOUR CURRENT HOSPITAL OR THE HOSPITAL YOU WERE MOST RECENTLY ASSOCIATED WITH.
(NOTE: REFERENCES WILL BE EVALUATED PRIMARILY BY THE EXTENT OF OBSERVATION OF CLINICAL SKILLS AND INTERACTION WITH THE APPLICANT.)

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

13. IF ANSWER TO ANY OF THE FOLLOWING THREE QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON SEPARATE SHEET OF PAPER.

- A. Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? Yes No
- B. Have your privileges at any hospital ever been suspended, modified, diminished, revoked or not renewed? Yes No
- C. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? Yes No
- D. Have judgements or settlements in professional liability cases been made against you, or are there any pending? If "YES", give details on separate sheet of paper Yes No
- E. Have you ever been reported to the National Practitioner Data Bank? Yes No

LIABILITY INSURANCE FOR CONTRACT PHYSICIANS, BOP PHYSICIANS WITH APPROVED PRIVATE EMPLOYMENT OR NEWLY RECRUITED PHYSICIANS	AMOUNT OF COVERAGE	INSURANCE CARRIER	EXPIRATION DATE
	POLICY NO.	AGENT	

14. I HEREBY APPLY FOR APPOINTMENT

PHYSICIAN IN THE BOP

CONTRACT PHYSICIAN

OTHER (SPECIFY)

REQUEST FOR MEDICAL PRIVILEGES
FEDERAL BUREAU OF PRISONS

PHYSICIAN'S NAME	INSTITUTION LOCATION	TYPE OF APPLICATION
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Privileges to practice medicine in the Bureau of Prisons are requested by clinical specialty and specific procedure. The capability of a particular institution to support the request is also taken into consideration by the BOP Governing Body. In all instances, procedures or treatments not specifically delineated are not precluded when:

1. The procedure or treatment is closely related technically or by body system to a delineated privilege of the provider, or:
2. The provider has training and current proficiency allowing reasonable clinical competence for the procedure or treatment.

Physicians will be granted privilege on initial employment and no less than every two years after initial employment.

CATEGORY I

Provide primary Ambulatory Care service (e.g., General Practice, General Internal Medicine, outpatient OB/Gyn). Includes clinical examination with appropriate investigation procedures, and treatment modalities.

Procedures Requested:

Non-invasion _____

Invasion _____

CATEGORY II

Physicians with these privileges are assigned to institutions with or without inpatient facilities and have the level of competence within a given field, and are board certified or board eligible. They are qualified to act as consultants to those in category 1 or 2.

Privilege Request:

CATEGORY III

Physicians with these privileges are assigned to institutions with or without inpatient facilities and have the highest level of competence within a given field, and are board certified. They are qualified to act as consultants for those in either categories 1 or 2.

CLINICAL AREAS

Designate the category (I, II, or III) to indicate the privileges you are requesting:

Primary Care

Specialty (specify) _____

Do you request privileges to admit patients? YES NO N/A

PRIVILEGES IN PSYCHIATRY

(for Psychiatrists Only)

PHYSICIAN'S NAME	INSTITUTION LOCATION	TYPE OF APPLICATION <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL
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PRIVILEGES REQUESTED

1. Diagnosis, Evaluation and/or Treatment (Indicate by number all applicable areas as indicated in Part A; if renewal, additions or deletions should be indicated as such and an explanation provided.)

2. Treatment Modalities (Indicate by number all modalities listed in Part B; if renewal, additions or deletions should be indicated as such and an explanation provided.)

LIST

A. Diagnosis, Evaluation and/or Treatment of:

1. Development disorders (mental retardation)
2. Organic mental disorders
3. Alcoholism
4. Psychoactive substance use disorders (drug abuse/misuse)
5. Schizophrenia
6. Delusional disorder
7. Mood disorders
8. Anxiety disorders
9. Somatoform disorders
10. Dissociative disorders
11. Sexual disorders
12. Impulse control disorders
13. Personality disorders
14. Adjustment disorders
15. Neurology disorders relevant to psychiatric practice
16. Other (specify)

B. Treatment Modalities / Special Competencies

1. Individual psychotherapy
2. Group therapy
3. Family therapy
4. Psychopharmacology
5. Forensic evaluation:
 - competency (4241 (b))
 - restoration of competency (4241 (d))
 - need for treatment (4243)
 - civil commitment (4245)
 - dangerousness (4246, 4244)
 - other (specify)
6. Special treatment techniques:
 - seclusion / restraint
 - sodium amytal interview
7. Crisis intervention
8. Psychometric testing
9. Behavior therapy (e.g. biofeedback, relaxation therapy, desensitization)
10. Psychoanalysis
11. Other (specify)

SPECIAL PROCEDURES

Please list the special procedures for which you are requesting privileges. Attach documentation indicating your qualifications for the procedure(s) requested. Your institution must be able to provide technical support for your request.

Special Studies/Invasive (examples: arterial puncture, flexible sigmoidoscopy, spinal tap)

Special Studies/Non-Invasive (examples: ECG Interpretation, Ultrasound, exercise treadmill testing)

Outpatient Surgical Procedures (specify)

I certify that, to the best of my knowledge and belief, all of the information associated with my request for privileges is true, correct, complete and made in good faith.

Applicant Signature: _____ Date: _____

DEPARTMENTAL / INSTITUTIONAL RECOMMENDATION (FOR STAFF PHYSICIANS)

- Recommended for privileges as requested
- Recommended for privileges with attached modification
- Recommended deferred at this time

Clinical Director / Department Chair _____
Date

Chair, Medical Staff / Committee _____
Date

Warden / Governing Body Representative _____
Date

GOVERNING BODY DISPENSATION (FOR CLINICAL DIRECTORS)

- Privileges are granted for a term of two years
- Privileges granted with attached modifications
- Temporary privileges granted for _____ days
- Privileges request deferred at this time
- Privileges request denied

Explanation for privilege deferment of denial:

Medical Director B.O.P. _____
Date

NOTE: The Medical Director, Bureau of Prisons grants privileges for all physicians who occupy the position of Clinical Director. The Clinical Director at the institution level grants privileges for other physicians.