BP-A0601 **APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF(PHYSICIAN)** CDFRM
JUN 10
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, ECT.				
	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				

6. PROFESSIONAL EXPERIENCE	LIST ALL PRESENT AND PREVIOUS PROFESSIONAL EXPERIENCE, IN CHRONOLOGICAL ORDER		
	NAME AND LOCATION OF HOSPITAL/ORGANIZATION	POSITION	DATES
	NAME AND LOCATION OF HOSPITAL/ORGANIZATION	POSITION	DATES
	NAME AND LOCATION OF HOSPITAL/ORGANIZATION	POSITION	DATES
7. BIBLIOGRAPHY	ON SEPARATE SHEET, FURNISH A LIST OF SCIENTIFIC PAPERS OR ESSAYS YOU HAVE WRITTEN, AND A LIST OF SCIENTIFIC MEETING YOU HAVE ATTENDED DURING PREVIOUS THREE YEARS (INCLUDE REPRINTS).		
8. MEMBERSHIP IN PROFESSIONAL SOCIETIES			
9. SPECIALTY BOARDS AND DATES			
10. CONTINUING MEDICAL EDUCATION	ON SEPARATE SHEET, LIST ALL POSTGRADUATE ACTIVITIES WHICH YOU HAVE ATTENDED, OR FOR WHICH YOU HAVE RECEIVED CREDIT IN THE PAST TWO YEARS		

11. LICENSE	MEDICAL LICENCE (NAME OF STATE AND COUNTY)	DATE	LICENSE NO.
	MEDICAL LICENCE (NAME OF STATE AND COUNTY)	DATE	LICENSE NO.
	MEDICAL LICENCE (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: REFERENCE WILL BE EVALUATED PRIMARILY BY THE EXTENT OF OBSERVATION OF CLINICAL SKILLS AND INTER ACTION 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 even been limited, suspended or revoked? Have your license been voluntarily surrendered, suspended, diminished, revoked or not renewed? If "Yes", give details on separate sheet of paper. ☐ Yes ☐ No

B. Have your privileges at any hospital ever been involuntarily suspended modified, diminished, revoked or not renewed?
Have your privileges been voluntarily surrendered, suspended, 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

Privileges to practice medicine in the Bureau of Prisons are requested by clinical training, experience, 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 privileges on initial employment and no less frequently 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, diagnostic procedures, and treatment modalities.

Procedures Requested:

Non-invasive_____

_____

Invasive_____

_____

☐ CATEGORY II

Ambulatory Care and Inpatient Care

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 for those in either categories 1 or 2.

Privilege Requested:

_____

_____

☐ CATEGORY III

Consultants - Non-BOP - Contract Physicians

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 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

☐ Special (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 ☐ Initial ☐ Renewal

PRIVILEGES REQUESTED

1. Diagnosis, Evaluation and/or Treatment (Indicate by number all applicable area 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. Delusion disorders
7. Mood disorders
8. Anxiety disorders
9. Somatoform disorders
10. Dissociative disorders
11. Sexual disorders
12. Impulse control disorder
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)
   - dangerous (4246, 4244)
   - other (specify)
6. Special treatment techniques:
   - seclusion / restraint
   - sodium amtal interview
7. Crisis intervention
8. Ppsychometric testing
9. Behavior therapy
   (e.g. biofeedback, relaxation therapy, densenitization)
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)

_____

_____

STATEMENT HEALTH AND ABILITY TO PERFORM REQUESTED PRIVILEGES

I am in good health and know no problems or conditions that would prevent me from performing duties or affect my performance within the scope of my privileges.

Applicant:_____ Date:_____

Confirmed by:_____ Date:_____

I certify that, to the best of my knowledge and belief, all 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 DIRECTOR)

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

Explanation for privilege deferment or 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.