

**UNITED STATES FLEET FORCES COMMAND
PERFORMANCE APPRAISAL REPORT**

SECTION I

Reporting Activity:	Period Covered:	Designator
Practitioner Name:	Grade:	SSN: NOT REQ
Specialty:	Dept.:	Position:

Purpose of Report

Granting of Staff Appointment <input type="checkbox"/> Initial <input type="checkbox"/> Active <input type="checkbox"/> Affiliate	<input type="checkbox"/> TAD	<input type="checkbox"/> Transfer <input type="checkbox"/> Separation <input type="checkbox"/> Termination
Renewal of Staff Appointment <input type="checkbox"/> Active <input type="checkbox"/> Affiliate	<input type="checkbox"/> AT/ADSW/ADT	Other Specify:

IPF has been Reviewed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unavailable for review
Contents are current as required by BUMEDINST 6320.66E:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

SECTION II - Privileges Being Evaluated:

	Specialty	Core	Supplemental	Itemized
1.				
2.				

Privilege information based on _____ privilege sheets or _____ appendix CTB (check one)

CLINICAL PERFORMANCE PROFILE

SECTION III - Practice Volume Data

a.	# of admission or outpatient encounters	/
b.	# of days unavailable due to TAD deployment, etc.	
c.	# of major or selected procedures	
d.	Percent of time in direct patient care	

SECTION IV - Medical Staff Quality Management Measures (Comments)

Within Standards

a.	Surgical/Invasive/Non-Invasive Procedures:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Use of Blood/Blood Components Utilization Review:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Drug Utilization Review:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Medical Record Pertinence Review (administrative):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e.	Medical Record Peer Review:	_____ # Records Reviewed	_____ # Records Deficient

Comments:

SECTION V - Dental Staff Performance Quality Management Measures (Comments)

Within Standards

a.	Dental Procedures Review	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b.	Drug Utilization Review	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c.	Dental Record Pertinence Review (administrative)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d.	Dental Record Peer Review:	_____ # Records Reviewed	_____ # Procedures Deficient

Comments:

SECTION VI

Facility Wide Monitors	Satisfactory	Unsatisfactory	Not Observed
a. Utilization Management			
b. Infection Control			
c. Incident Reports/Management Variance Reports			
d. Patient Contact/Satisfaction Program			
e. Risk Management Activities			

NOTE: For any item marked "Unsatisfactory" in section VI, provide full details in section XII or on a separate sheet of paper and attach to this form. Identify items by section and letter.

SECTION VII - Professional Development

a.	# of continuing education credit hours awarded:
b.	# of papers published and professional presentations:
c.	Other recognition's of positive professional achievement (Attach explanation/comments):

SECTION VIII

	EVALUATION EVENTS	Satisfactory	Unsatisfactory	Not Observed
a	Basic professional knowledge			
b	Technical skill/competence			
c	Professional judgment			
d	Ethical conduct			
e	Participation in staff, department, committee meetings			
f	Ability to work with peers and support staff			
g	Ability to supervise peers and support staff			

NOTE: For any item marked "Unsatisfactory" in sections VIII, provide full details in section XII or on a separate sheet of paper and attach to this form. Identify items by section and letter.

SECTION IX- Privileging Actions: If the answer to any of the following questions is "Yes" provide full details in section XII or on a separate sheet of paper and attach to this form. Identify items by section and letter.

To your knowledge has the practitioner:

Yes or

No

a.	Had privileges or staff appointment adversely denied, suspended, reduced, or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Been the primary subject of an investigation?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Provided substandard care substantiated through one of the actions in item b?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Required counseling, additional training, or special supervision?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Failed to obtain appropriate consultation?	<input type="checkbox"/>	<input type="checkbox"/>
f.	Been the subject of a disciplinary action for misconduct?	<input type="checkbox"/>	<input type="checkbox"/>
g.	Required modification of practice due to health status?	<input type="checkbox"/>	<input type="checkbox"/>
h.	Been diagnosed as being alcohol dependent or having an organic mental disorder or psychotic disorder?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION X - Clinical Competency CORE Privileges: Address overall clinical competency of this provider (attach additional sheets and identify section as needed)

SECTION XI - Clinical Competency Supplemental Privileges: Address overall clinical competency of EACH supplemental privilege granted and provide number of cases/procedures for each supplemental privilege practiced during this appointment cycle. (attach additional sheets and identify section as needed)

SECTION XII - Comments: If the answer to any of the questions in section VI, VIII or IX is "unsatisfactory" or "yes" provide full details below or on a separate sheet of paper and attach to this form. Identify items by section and letter.

SECTION XIII. PRIVILEGES AUTHORITY SIGNATURES

Title	Printed Name	Signature	Comments Attached (Yes / No)	Date
Dept Head / SMO / SDO				
Practitioner				
ECOMS Reviewer				
Privileging Authority				
