

UNITED STATES FLEET FORCES COMMAND
CLINICAL APPRAISAL REPORT

SECTION I

Reporting Activity:	Period Covered:	Designator: 2900
Practitioner Name:	Grade:	SSN: Not required
Specialty: Registered Nurse	Dept.: Medical	Position:

Purpose of Report

Granting of Staff Appointment	<input type="checkbox"/> Initial <input type="checkbox"/> Active <input type="checkbox"/> Affiliate	<input type="checkbox"/> TAD	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	<input type="checkbox"/> Other Specify:

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

SECTION II - 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 III – Scope of Clinical Responsibility:

a.	Major patient population served:
b.	Age / sex / unique features of population served (retired, geriatric, recruits, etc.):
c.	Acuity level:
d.	Average length of stay for major population served:
e.	Average outpatient visits:

SECTION IV - Clinical Performance

	Evaluation Elements	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", provide full details in section VII or on a separate sheet of paper and attach to this form. Identify items by section and letter.

SECTION V - Other Information

If the answer to any of the following questions is "Yes", provide full details in section VII 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 licensure / clinical certification or functions suspended, limited, or revoked?	<input type="checkbox"/>		<input type="checkbox"/>
b.	Received a formal letter of warning regarding clinical performance?	<input type="checkbox"/>		<input type="checkbox"/>
c.	Been the primary subject of a malpractice action, claim, a JAGMAN investigation, or healthcare review inquiry?	<input type="checkbox"/>		<input type="checkbox"/>
d.	Had standard care substantiated through one of the actions noted above?	<input type="checkbox"/>		<input type="checkbox"/>
e.	Required counseling, additional training or special supervision in response to performance, quality monitoring, or legal problems?	<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 job assignment due to unsatisfactory performance?	<input type="checkbox"/>		<input type="checkbox"/>
h.	Failed to obtain appropriate consultation?	<input type="checkbox"/>		<input type="checkbox"/>
i.	Required modification of job assignment due to health status?	<input type="checkbox"/>		<input type="checkbox"/>
j.	Been diagnosed as being alcohol dependent or having an organic mental disorder or psychotic disorder?	<input type="checkbox"/>		<input type="checkbox"/>

