NAVAL HOSPITAL LEMOORE
EMERGENCY CLINICAL PRIVILEGES FORM

I certify I am licensed/certified as a _____ in the state of _____, license # _____. I certify that I have the education, training, current competency, ability to perform, and experience to practice in the specialty of _____.

I hereby volunteer my professional service to Naval Hospital Lemoore (NHL) during this disaster and agree to practice, as directed, and under the supervision/observation of a member of the medical staff of NHL.

I acknowledge my privileges at NHL shall **immediately terminate** once the emergency has ended, as notified by the hospital.

_____ _____
Practitioner Signature Date

The information provided by the practitioner was reviewed and verified, as possible, by Professional Affairs. On this basis, this practitioner is hereby granted emergency privileges to treat patients presenting to NHL during this disaster.

Practitioner contact information:
Printed Name: _____
Address: _____
Home Phone: _____ **Work Phone:** _____

Document viewed: (a current hospital photo ID, **or** a current medical/dental/nursing license and a photo ID, **or** member of a Disaster Medical Assistance Team (DMAT) ID, **or** ID certifying a state, federal or municipal entity has granted authority to administer patient care in emergency circumstances, **or** presentation by a current NHL staff member with personal knowledge regarding practitioner's identity.) Include ID type, number, issuing organization, expiration date:

_____

_____

_____

_____ _____
HEAD MANPOWER POOL/OOD/MSSP By Direction Date

_____ _____
CHAIRMAN, ECOMS (MSSP will have completed after emergency) Date

_____ _____
COMMANDING OFFICER (MSSP will have completed after emergency) Date

NHLEM Form 3440/3 (07/08)