

NORTHEAST FLORIDA HOSPITALS

CONFIDENTIAL EVALUATION FOR LICENSED INDEPENDENT PRACTITIONERS

Applicant Name:

PROGRAM TRAINING DATES (mo/yr): _____ to _____ N/A

1. How do you know the applicant? _____
2. Where did you observe this applicant's professional performance?
Hospital/Office Name: _____
3. What was the timeframe for this observation/training? From _____ (mm/yy) To _____ (mm/yy)
4. Staff Category: _____ Specialty: _____

We would appreciate your candid appraisal of the following:

Indicator	Poor *	Average	Good	Excellent
Basic Clinical Knowledge				
Professional Performance				
Clinical and/or Technical Skills				
Sense of Responsibility/Attitude				
Patient Management				
Ethical Conduct				
Cooperativeness				
Ability to work with others				
Medical Records (timely completion)				
Medical Records (quality of documentation)				
Quality/Appropriateness of Care Outcomes				
Communication Skills				

HEALTH INFORMATION

Is the applicant able to safely and competently perform the essential functions of the requested privileges? Yes No*

DISCIPLINARY ACTIONS

- Has the applicant been subject to any disciplinary action or are any actions pending? Yes* No
- Has the applicant been involved in any professional liability claim or action? Yes* No
- Has the applicant been under investigation by any governmental or legal body? Yes* No

COMPETENCE - Please review the enclosed request for clinical privileges made by this applicant.

Based on your knowledge of the applicant, is he/she qualified and competent to perform all requested privileges? Yes No*

***For any responses that are asterisked, please explain the reason for this response.**

RECOMMENDATIONS

- Recommend without reservation
- Recommend with the following reservations: _____
- Do Not Recommend

COMMENTS: _____

Do you have additional comments you would like to share? YES NO

SIGNATURE: _____
 NAME (printed or typed) _____
 PHONE NUMBER: _____

DATE: _____
 TITLE: _____
 FAX NUMBER: _____

PLEASE RETURN THIS FORM TO: