PROFESSIONAL REFERENCE

Regarding: _____ Specialty: _____

Please answer the following questions to the best of your knowledge in regards to the Provider above.

1. How long have you been associated with the Provider? _____ years
2. In what capacity? ☐ Colleague ☐ Training Director/Attending ☐ Supervisor ☐ Other
3. Please describe the setting in which you observed the Provider's work. _____
4. Is your clinical contact with the Provider within the last two years? ☐ Yes ☐ No
5. Does the Provider know his/her limitations and refers or consults appropriately? ☐ Yes ☐ No
6. Do you have any reason to believe the Provider would pose a risk to his/her patients? ☐ Yes ☐ No
7. Are you aware of any investigations or disciplinary actions regarding his/her hospital privileges? ☐ Yes ☐ No
8. Are you aware of any disciplinary actions or problems related to his/her professional competence? ☐ Yes ☐ No
9. Are you aware of any issues that might affect the Provider's work? ☐ Yes ☐ No
10. Would you feel comfortable with the Provider treating you or a member of your family? ☐ Yes ☐ No
11. Hypothetically, would you hire the Provider? ☐ Yes ☐ No

Please explain. _____

12. What are the Provider's strongest characteristics? _____
13. What weak or negative aspects are you aware of in the Provider's performance? _____

Please use the following scale to rate the Provider in each of the areas below:
1 = Poor 2 = Average 3 = Good 4 = Excellent N/A = Not Applicable

14. Clinical Skills: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
15. Medical Knowledge: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
16. Professional Competence: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
17. Professional Experience: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
18. Patient Rapport: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
19. Colleague Rapport: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
20. Staff/Nursing Rapport: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
21. Ability to get along with Administration: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
22. Ability to follow rules/procedures: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
23. Charting and Documentation Habits: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A
24. Ability to adapt to new and different situations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ N/A

☐ I authorize this information to be shared. ☐ I do NOT authorize this information to be shared.

_____ _____
Signature of Reference Date

_____ _____ _____
Printed Name Specialty Phone Number

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