

# 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