Your Center Name Here
Professional Peer Reference Questionnaire

Name of Applicant:

Area of Clinical Privileges Requested:

Name of Reference Practitioner:

Current Position of Reference Practitioner:_____

Time period of observations:_____

Location of observations:_____

Position at time of observation: _____

Type of clinical procedures observed: _____

Please indicate your evaluation of the practitioner based on your observations in comparison with those practicing similar specialties:

Criteria	Excellent	Above Average	Average	Below Average
Overall Ability				
Technical Skills				
Professional Judgement				
Compliance to Regulatory Requirements/Standards/ Staff Bylaws				
Professional Behavior/Interpersonal Skills				
Communication Skills				

Please describe any strengths or weaknesses observed:_____

To your knowledge, does the practitioner have any condition which could compromise his ability to perform any of the mental and physical functions related to the requested clinical privileges? _____ Yes ____ No If yes, please explain:_____
_____

To your knowledge, has the practitioner ever been denied membership or clinical privileges for any hospital system or medical staff? _____ Yes _____ No If yes, please explain: _____
_____.

Please review the attached copy of "Requested Delineation of Privileges". Do you concur that these privileges match the experience for this physician, and that he is qualified by training and experience to be approved for the requested privileges? _____Yes _____No If no, please explain: _____
_____
_____

Any additional information which may be relevant to the evaluation of the practitioner: _____
_____
_____

Signature/Title:_____Date:_____