

DIVISION OF HEALTH CARE SERVICES - CORRECTIONAL TREATMENT CENTER

PROFESSIONAL REFERENCE RE: _____

Please answer all questions based on your personal knowledge and direct observation. Your candor will be greatly appreciated, and your answers will be confidential.

1. How long have you known the applicant? _____
2. During that time period, did you have the opportunity to directly observe the applicant's practice of medicine? Yes No If yes, please explain on reverse side of form.
3. In what settings did you observe the applicant? i.e., office, hospital, etc.: _____
4. Are you now, or about to become, related to the applicant or through a professional partnership or financial association? Yes No If yes, please explain on reverse side of form.

Please review the attached privilege request. If you feel you do not have adequate knowledge, please answer "No information".

SCALE 1 Poor 2 Marginal 3 Average 4 Good 5 Outstanding 9 No information

PERFORMANCE	1	2	3	4	5	9
A. Medical Knowledge						
B. Technical and Clinical Skills						
C. Availability for and Thoroughness in Patient Care						
D. Relationship with Patients						
E. Ability to Communicate						
F. Relationship with Other Practitioners						
G. Relationship with Other Health Care Providers						
H. Relationship with Hospital Administration/Staff						
I. Participation in Medical Staff Affairs						

5. Please indicate and explain any reservations, concerns or recommendations concerning specific privileges requested by the applicant: _____
6. Please add any comments relevant to the applicant's medical knowledge, competence, and demonstrated skill and abilities. Are there any clinical areas, procedures, or patient severity levels for which you are concerned about the applicant's ability? Use the reverse side of this form if necessary: _____
7. Have you observed or been informed of any physical/mental health/drug or alcohol dependencies or other problems which the applicant has that have impaired or could potentially impair ability to exercise all or any of the privileges requested? Yes No If yes, please explain on reverse side of form.
8. To the best of your knowledge, has the applicant's license, clinical privileges, health care organization staff membership or other professional status ever been denied, challenged, suspended, revoked, modified, or voluntarily surrendered? Yes No If yes, please explain on reverse side of form.
9. To your knowledge, has the applicant ever been a defendant in a medical malpractice action?

<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, was the matter:	<input type="checkbox"/> Settled out of court	<input type="checkbox"/> Applicant found liable
		<input type="checkbox"/> Brought to trial	<input type="checkbox"/> Applicant found <u>not</u> liable
		<input type="checkbox"/> Matter still pending	

Signature

Date

Please Print Name and Title