



ADVANCED CARE PROVIDERS
PROFESSIONAL REFERENCE QUESTIONNAIRE



APPLICANT NAME:	DATE:
------------------------	--------------

The above-named applicant is seeking appointment/reappointment to the Staff of Advanced Care Providers and will be requesting assignment of clinical privileges at medical facilities. To facilitate evaluation of the practitioner's clinical abilities and staff citizenship, we request that you answer the following questions, based on your personal knowledge and direct observation. Your candidness will be greatly appreciated and your answers will be confidential, except as necessary for accomplishing any credentialing process or for any related due process procedures.

RELATIONSHIP OF REFERENCE SOURCE TO PROVIDER

1.	How long have you known this provider?
2.	During what time period have you had the opportunity to directly observe this provider's clinical skills?
3.	In what setting(s) and with what frequency did you observe this provider? (i.e. hospital, office, etc.)
4.	What is YOUR specialty (or what are your credentials)?

PROFESSIONAL KNOWLEDGE, SKILLS AND ATTITUDE

Clinical privileges may be requested at a variety of medical facilities.

Please rate the following:	Poor	Marginal	Average	Good	Excellent	No Info.
1. In general, I would classify this provider's medical knowledge as:						
2. In general, I would classify this provider's technical and clinical skills as:						
3. I believe this provider's clinical judgment is:						
4. I believe this provider's attitude is:						
5. This provider's ability to communicate, work and cooperate with other staff, physicians, nurses, students, health professionals, hospital administration, support staff and patients is generally:						
6. I would classify this provider's availability for, and thoroughness in, patient care as:						
7. Based on personal knowledge and observations, I believe that the provider's qualifications and skills are:						
8. Please add any additional comments relevant to this provider's medical knowledge, competence, demonstrated skills and abilities. Are there any clinical areas, requested privileges/procedures, or patient severity levels for which you are concerned about this individual's ability?						

APPLICANT: _____

<p>9. Have you ever been informed of or observed any physical, mental health, drug or alcohol dependency or other problems which this provider has or has had that have or could potentially impair his/her ability to exercise any or all of the privileges requested?</p> <p>If yes, please explain.</p>	<p>Yes</p>	<p>No</p>
<p>10. To the best of your knowledge, has this provider's license, position, certification, clinical privileges, hospital staff membership or other professional status ever been denied, challenged, suspended, modified, investigated, revoked, placed on probation, made subject to an individual focused review, not renewed, voluntarily surrendered, or do you have knowledge to any such pending actions?</p> <p>If yes, please explain.</p>	<p>Yes</p>	<p>No</p>
<p>11. Do you know of any malpractice actions initiated and/or currently pending against this provider?</p>	<p>Yes</p>	<p>No</p>
<p>12. To the best of your knowledge, has this provider ever been a defendant in a felony criminal matter or misdemeanor involving moral turpitude or any other misdemeanor?</p> <p>If yes, what was the nature of the allegation(s) and the finding (guilty, not guilty, pending, trial/appeal, unknown, etc.)</p>	<p>Yes</p>	<p>No</p>
<p>Additional comments, concerns, reservations, other information or recommendations which you believe would be relevant in granting affiliation and clinical privileges.</p>		

Do you have any additional information in regard to this provider that you would like to discuss personally?

Yes _____ No _____ Phone No. _____ Best time to call _____

SUMMARY RECOMMENDATION

_____ I recommend without reservation for appointment.

_____ I recommend. Please note reservations listed above.

_____ I do not recommend this applicant.

Name -

Signature -

Date

Return to:
PO Box 972, Minocqua, WI 54548
Fax #: 323-375-3290 E-Mail: mike@acpstaff.com
Questions or comments please call 715-661-0030