DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date: 6/30/2016

SUGGESTED FORMAT FOR LETTER TO BE SENT TO REFERENCES OF APPLICANTS OR FOR TELEPHONE SOLICITATION OF REFERENCES

Date

Name
Address

Dear Dr./Mr./Ms. _____:

Dr./Mr./Ms. _____ has applied for membership to the medical staff of the Indian Health Service hospital/clinic in _____[location]_____.

We are in the process of validating information contained in his/her application and are asking that you provide us with your assessment of Dr./Mr./Ms. _____ in regards to his/her professional judgment, competence, and personal character. Also, please note the extent to which you have worked with the applicant and/or observed his/her clinical performance. A check sheet has been enclosed with this letter to facilitate your evaluation. Some or all of the information you give us could in the future be released to a State licensing board or similar entity, to other agencies of the Federal Government, or for legal purposes. Your response is voluntary; however, we hope that you will provide this information to us so that we can process Dr./Mr./Ms. _____'s application with the most accurate information possible.

Sincerely,

Clinical Director

IHS MEDICAL STAFF PROFESSIONAL REFERENCE CHECKLIST

APPLICANT'S NAME: _____ **DATE:** _____

APPLICANT'S POSITION: _____

AFFILIATION DATES: _____

THIS REFERENCE IS BASED ON:

Direct Observation	☐	**Indirect Observation**	☐
frequent	☐	frequent	☐
occasional	☐	occasional	☐
infrequent	☐	infrequent	☐

Discussion With Others Who Have Direct Knowledge:

Records Only: ___

EVALUATION OF APPLICANT:

Knowledge/Skills	Excel-lent	Very Good	Averag e	Below Aver-age*	Unable to Assess *
Diagnostic abilities	☐	☐	☐	☐	☐
Clinical skills	☐	☐	☐	☐	☐
Surgical skills	☐	☐	☐	☐	☐
Fund of knowledge	☐	☐	☐	☐	☐
Patient rapport	☐	☐	☐	☐	☐
Peer rapport	☐	☐	☐	☐	☐
Maintenance of medical records	☐	☐	☐	☐	☐
Staff meeting participation	☐	☐	☐	☐	☐
Compliance with medical staff bylaws/rules & regulations	☐	☐	☐	☐	☐
Productivity	☐	☐	☐	☐	☐
Motivation	☐	☐	☐	☐	☐
Integrity/ethics	☐	☐	☐	☐	☐
Health status	☐	☐	☐	☐	☐

*Please explain: _____

_____

_____

ARE YOU AWARE OF ANY SUBSTANCE ABUSE/DEPENDENCY PROBLEMS, CURRENT OR PAST?

_____

_____

_____

TO YOUR KNOWLEDGE, DOES THIS APPLICANT HAVE ANY MEDICAL MALPRACTICE SUITS PENDING?

Yes ☐ **No** ☐

ARE YOU AWARE OF ANY SUBSTANCE ABUSE/DEPENDENCY PROBLEMS, CURRENT OR PAST?

_____

_____

Signed: _____ **Title:** _____

Print: _____

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.