



DEPARTMENT OF VETERANS AFFAIRS

In Reply Refer To:

Dear _____

_____ has applied to the Department of Veterans Affairs for employment as a _____ and has given your name or institution as a reference.

To help us determine if this applicant meets the requirements for employment, we would appreciate your completing the questions on the reverse side of this letter. Please be entirely frank and answer all applicable questions as fully and specifically as you can.

For your convenience, we have enclosed a self-addressed envelope that requires no postage. Thank you for your help in this matter.

Sincerely yours,

The information you provide on the individual named above will be disclosed to the individual on his or her request.

Paperwork Reduction Act and Privacy Act Notices. We are required to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. Title 38, United States Code, Chapter 73, grants the VA the authority to request such information. Please understand that we regard the provision of this information on your part as voluntary. Response is voluntary, however failure to provide the information may result in our inability to determine the applicant's qualifications. This collection of information is intended to provide a tool to judge an applicant's suitability for employment. Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency. It may be used to check the National Practitioner (HIPDB) or List of Excepted Individuals (LEIE) Data Banks which are administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining the suitability of the applicant for a clinical training appointment. This information may also be used to periodically verify, evaluate and update clinical privileges, credentials and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program at any time.



APPRAISAL OF APPLICANT

A. APPLICANT INFORMATION

1. NAME OF APPLICANT	2. SOCIAL SECURITY NUMBER
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B. FOR EMPLOYERS ONLY

3. HOW LONG HAVE YOU KNOWN THE APPLICANT PROFESSIONALLY?	4. WHAT HAS BEEN YOUR RELATIONSHIP WITH THE APPLICANT?	
5. APPLICANT WAS EMPLOYED <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	6. DATES OF EMPLOYMENT FROM _____ TO _____	7. AVERAGE HOURS APPLICANT WORKED PER WEEK

NOTE: Please check the appropriate column for each performance factor

PERFORMANCE FACTORS	UNSATISFACTORY	WEAK	SATISFACTORY	HIGHLY SATISFACTORY	EXCELLENT
8a. CLINICAL KNOWLEDGE					
8b. CLINICAL COMPETENCE/SKILLS					
8c. EMOTIONAL STABILITY					
8d. ABILITY TO WORK EFFECTIVELY WITH OTHER STAFF MEMBERS AND SUPERVISORS					
8e. DEPENDABILITY					
8f. INSTRUCTIONAL SKILLS					
8g. ADMINISTRATIVE COMPETENCE					

9. WOULD YOU REHIRE THIS APPLICANT? <input type="checkbox"/> YES <input type="checkbox"/> NO (if "NO," explain in Remarks)	10. REASON APPLICANT LEFT YOUR EMPLOYMENT	
11. TO YOUR KNOWLEDGE, HAS THE APPLICANT EVER HAD ANY LICENSE REVOKED, SUSPENDED, DENIED, RESTRICTED LIMITED, OR ISSUED/PLACED IN A PROBATIONAL STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO (if "YES," explain in Remarks)	12. TO YOUR KNOWLEDGE HAS THE APPLICANT EVER HAD CLINICAL PRIVILEGES? <input type="checkbox"/> YES <input type="checkbox"/> NO	13. TO YOUR KNOWLEDGE, HAVE ANY OF THESE PRIVILEGES EVER BEEN DENIED, REVOKED, OR VOLUNTARILY RELINQUISHED? <input type="checkbox"/> YES <input type="checkbox"/> NO (if "YES," explain in Remarks)

C. FOR EDUCATIONAL INSTITUTIONS ONLY

14. DATE GRADUATED	15. RANK IN CLASS	16. GRADE POINT AVERAGE
17. STRONG SUBJECTS		
18. WEAK SUBJECTS		

D. REMARKS

19. SIGNATURE	20. POSITION	21. DATE
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