



Address

VERIFICATION OF AFFILIATION

August 2, 2023

«RS_Name»

«RS_Address»

«RS_City», «RS_State» «RS_Zip»

Fax Number: «RS_Fax»

Re: «FormalNameWithDegree»

The practitioner listed above has applied for appointment/reappointment at «FacilityName» Indian Medical Center. Please verify the information requested below. «Hisher» consent for release of information is attached «Image:File_REL». Please return via secure email or fax to **Attn: «UserFullName», «UserFax»**. Thank you.

«UserFullName»

Medical Staff Professional

URGENT

Dates of Staff Membership: From _____ To _____ Observed? ___ Unobserved? ___

Staff Category: _____ Approximate number of patient contacts in the past year: _____

- 1. Has applicant’s clinical privileges ever been denied, revoked, restricted, or granted with limitations? **YES*** ___ **NO** ___
- 2. Did «heshe» attempt procedures beyond his/her skills or training? **YES*** ___ **NO** ___
- 3. Has the applicant’s medical staff membership or status at your hospital ever been revoked, not renewed, or subject to probationary conditions, or have proceedings begun that could result in any such action? **YES*** ___ **NO** ___
- 4. Are you aware of any malpractice litigation or claims involving the applicant? **YES*** ___ **NO** ___
- 5. Do you know of any behavioral, health, substance abuse, or quality of care problems for which the applicant was disciplined or counseled while on staff at your facility? **YES*** ___ **NO** ___
- 6. Would you recommend «himher» for appointment to our medical staff? **YES** ___ **NO*** ___
- 7. Do you find this provider to be ethical and of high moral character? **YES** ___ **NO*** ___
- 8. Evaluation completed: (*Provide explanation)

_____ **Based on close observation and/or personal knowledge.**

_____ **Based on review of Credentials file.**

Comments:

Signature: _____ Title: _____

Printed Name: _____ Phone: _____ Date: _____