

PROFESSIONAL REFERENCE – INDIAN HEALTH SERVICE

Applicant Name: «FormalNameWithDegree»

Date: August 2, 2023

(The reference form must be completed by a peer from your own profession; e.g., reference for a FNP from a FNP)

Reference Name: «RS Name»

Please answer the following questions based on your personal knowledge as a peer of this practitioner. *Note: If your response to any of the following is "below average", please supply a written explanation on a separate sheet of paper.

EVALUATION	Above Average	Satisfactory	Below Average*	Not Applicable
PATIENT CARE/MEDICAL & CLINICAL KNOWLEDGE				
Basic Medical Knowledge				
Professional Judgment				
Clinical/Technical Skills				
Positive Patient Outcome/Results				
Appropriate Utilization of Resources				
Appropriate Use of Consultations				
Appropriate Use of Medication				
INTERPERSONAL & COMMUNICATION SKILLS WITH:				
Patients				
Superiors/Administrations				
Colleagues/Peers/Clinical Support Staff				
Ability to Understand, Speak, Read and Write English				
PROFESSIONALISM				
Availability/Responsiveness				
Ethical Conduct				
Emotional Stability				
Moral Character				
SYSTEMS-BASED PRACTICE				
Medical Record Timeliness				
Compliance with Medical Staff Bylaws, MS Policies				
PRACTICE-BASED LEARNING & IMPROVEMENT				
Investigates and evaluates patient care practices				
Appraise and assimilates scientific evidence				
Improves the practice of medicine				

- How long have you known the practitioner? _____
- What is your relationship to the practitioner? _____
- When was the last time you observed the practitioner provide patient care ? _____ Direct Observation? _____ Indirect Observation? _____
- To your knowledge, does this applicant have any medical malpractice suits? () Yes () No If yes, please provide an explanation on a separate sheet of paper.
- Would you hire/rehire this practitioner? () Yes () No If no, please provide an explanation on a separate sheet of paper.
- Would you be comfortable having your friends or family treated by this applicant? () Yes () No If no, please provide an explanation on a separate sheet of paper.
- To your knowledge, does the practitioner have any physical or mental impairments that could possibly affect his/her ability to exercise requested privileges? () No () Yes If yes, please provide a full explanation on a separate sheet of paper.
- To your knowledge, does the practitioner suffer from alcohol or drug abuse or dependency? () No () Yes If yes, please provide a full explanation on a separate sheet of paper.
- As a peer of the above named practitioner, I: (Please select one below):
 - ____ Recommend as Qualified and Competent to perform the attached privileges.
 - ____ Recommend with Reservation (please provide a full explanation on a separate sheet of paper)
 - ____ Do not Recommend (please provide a full explanation on a separate sheet of paper)

Signature: _____ Date: _____

Title: _____ Phone: _____

Please return the form DIRECTLY to the Medical Staff Office, we cannot accept from a 3rd party.

Return to: «FacilityName» Facility Address/secure email/fax

«Image:File_Privilege»