Physician Evaluation Form

(Example)

Date

Reference's Name
Street Address
City, State, ZIP

RE: (Candidate Name)

VERIFICATION

The above physician has provided your name as a personal reference.

Indicate the number of years or length of time known: _____

EVALUATOR INFORMATION

Your current position/title: _____

Your relationship to the applicant is/was: _____

The information provided on this form was obtained from:

- ☐ Close personal observation in a supervisory role.
- ☐ A composite of written and/or verbal evaluations by others in authority.
- ☐ General impression from personal observation in a non-supervisory role.
- ☐ Other – please explain below.

Physician Evaluation Form

(Example Continued)

RE: (Candidate Name)

APPLICANT EVALUATION

This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience, and background.

EVALUATION	1 Superior	2 Good	3 Fair	4 Poor	0 Not Observed
Basic Medical & Clinical Knowledge					
Professional Judgment					
Sense of Responsibility					
Ethical Conduct					
Emotional Stability					
Competence in Clinical & Technical Skills					
Cooperativeness, Ability to Work With Others					
Appearance					
History & Physical Exam Taking					
Medical Record Maintenance					
Quality Assurance					
Patient Management					
Physician-Patient Relationship					
Ability to Understand, Speak & Write English					
Relationship With Hospital Staff					
Participation in Medical Staff					
Attendance at Meetings					

Physician Evaluation Form

(Example Continued)

RE: (Candidate Name)

CORRECTIVE ACTION

To your knowledge, during the time known to you or as documented in your hospital's or institution's records by others in authority:

Has this applicant ever been subject to any investigation or disciplinary action (including but not limited to the following): admonition, reprimand, suspension or termination by a licensing authority, Board of Trustees, or Medical Staff?

1. For unethical conduct YES _____ NO _____ Unknown _____

2. For any other reason YES _____ NO _____ Unknown _____

In your opinion, has the applicant ever shown signs of not being able to safely perform all elements and requirements of his/her clinical privileges?

YES _____ NO _____ Unknown _____

Has/had the applicant ever interrupted his/her medical practice or been unable to perform all elements of the clinical privileges for which they have applied?

YES _____ NO _____ Unknown _____

RECOMMENDATION(S)

Please indicate your recommendations of this applicant for appointment to the Medical Staff of (your organization):

☐ I would highly recommend this applicant without reservation.

☐ I would recommend this applicant as qualified and competent.

☐ I do not recommend this applicant.

Physician Evaluation Form

(Example Continued)

RE: (Candidate's Name)

COMMENTS

If needed, list any notable strength, weaknesses or any explanation of previous listed answers here:

_____
_____
_____

What is the best day and time to contact you by telephone?

DAY:_____

TIME:_____ AM/PM

Phone Number: (__ __ _)_ _____

This evaluation form was completed by me personally. It is my understanding that the information provided will be used by the (Department Name) of (Organization's Name) for (Purpose) and will be held in strict confidence.

DATE: _____

_____
Signature

_____
Title

_____
Print or Type Name