Professional Reference Evaluation- Clinical Practitioner

Name: _____Specialty: _____

The above practitioner has requested participation with WholeHealth Networks, Inc. (WHN). The applicant has signed "Authorization for Release of Information" for your evaluation during the WHN credentialing process. Please provide your candid evaluation of the practitioner, attaching additional sheets if necessary. If you answered "Yes" to questions 5-9, please provide additional documentation. <u>All information will be held in the strictest of confidence</u>.

1.) **During what time period and in what settings (i.e.. community practitioner office, hospital internship, or program) did you observe the applicant?**

2.) **Indicate your overall evaluation of the applicant based on your observations, in comparison with the practitioner's peers who have similar training and experience, by rating each skill on a scale of 1-10.**

	Poor Average Superior
Clinical Skills	1 2 3 4 5 6 7 8 9 10
Clinical Judgement	1 2 3 4 5 6 7 8 9 10
Clinical Knowledge	1 2 3 4 5 6 7 8 9 10
Case Presentations for Advice/Consults	1 2 3 4 5 6 7 8 9 10
Medical Records Keeping	1 2 3 4 5 6 7 8 9 10
Decision Making Skills	1 2 3 4 5 6 7 8 9 10 Patient
Rapport	1 2 3 4 5 6 7 8 9 10 Colleague
Rapport	1 2 3 4 5 6 7 8 9 10 Sense of
Responsibility	1 2 3 4 5 6 7 8 9 10 Emotional Stability
	1 2 3 4 5 6 7 8 9 10

3.) **What are the applicant's strengths? _____**

4.) **Do you know of any circumstances that would inhibit the practitioner in his/her practice? ____YES ___NO**

5.) **Are you aware of any ongoing physical/mental conditions (including substance abuse issues) that would interfere with the performance of the applicant's essential functions? ____YES____NO**

6.) **Are you aware of any concerns regarding his/her professional abilities, character, ethics or relationship with peers, staff and patients? _____YES_____NO**

7.) **Are you aware of any information or an action (complete or pending) regarding malpractice, professional licensed proceedings, denials, revocations, suspension, limitations or staff privileges, non-renewal or voluntary withdrawal of the applicant's participation in their current role, an educational training program or professional association? ____YES ____NO**

8.) **Are there any clinical areas, procedures or patient security levels for which there may be basis for concern about the applicant's ability to provide appropriate care? ____YES ____NO**

Evaluation Completed by: _____Date: _____

Print Name/Title: _____

Updated 10/17/2017