618-391-6140
618-288-2164 FAX
MSO@AndersonHospital.org

PROVIDER PEER REFERENCE

Applicant: _____ Specialty: _____

The above provider has applied for medical staff appointment to the staff of Anderson Hospital. The applicant has given your name as a reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this provider's application for surgical privileges. Your response will be treated as confidential.

Criteria	Excellent	Above Average	Average	Below Average
Clinical Knowledge	☐	☐	☐	☐
Clinical Judgement	☐	☐	☐	☐
Technical Proficiency	☐	☐	☐	☐
Professional Relations with Patients	☐	☐	☐	☐
Ethical Conduct	☐	☐	☐	☐
Record Keeping	☐	☐	☐	☐

1. How long have you known the above named applicant: _____ year(s).
   From:_____ to _____
   (month/year) (month/year)

2. In what setting(s) and with what frequency did you observe the applicant? (i.e. office, hospital residency program, etc./daily, weekly, month, etc.) _____
   _____
   _____

3. Would you be pleased to have this applicant as an associate with you in practice?
   ☐ Yes ☐ No

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4. To your knowledge, does the provider have any condition which could compromise his ability to perform any of the mental and physical functions related to the requested clinical privileges? ☐ Yes ☐ No

   If yes, please explain: _____

5. To your knowledge, has the provider ever been denied membership or clinical privileges for any hospital system or medical staff? ☐ Yes ☐ No

   If yes, please explain: _____

6. Any additional information which may be relevant to the evaluation of the provider:

My recommendation concerning this provider's application for appointment/affiliation is:

☐ Recommend

☐ Recommend with reservation*

☐ Not recommended*

*Please explain any reservations or concerns regarding the applicant's request for appointment/affiliation:

Signature/Title: _____ Date: _____

Printed Name: _____