Anderson Healthcare

PEER REFERENCE

(Reference must have a like degree and have personal knowledge, of at least 6 months within the past 12 months, of the applicant's current clinical abilities, ethical character and interpersonal skills and who can attest to their current competence)

Applicant: _____ **Specialty:** _____

The above named provider has applied for appointment or reappointment and privileges to an Anderson Healthcare Entity/Entities. The applicant has provided 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 membership/ privileges. Your response will be treated as confidential.

1. Have you known the applicant for at least 6 months within the past 12 months? ☐Yes ☐No
   a. Please provide the timeframe for which you have known and/or observed the applicant:

      From:_____ To:_____
      (Month/Year) (Month/Year)

2. Based on your personal knowledge, is the applicant in good mental, physical and emotional health and clinically competent to perform the scope of practice/privileges requested on the attached form(s)? ☐Yes ☐No

   If no, please explain:_____

   _____

3. Please evaluate the applicant based on demonstrated performance compared to that reasonably expected of a practitioner at this provider's level of training, experience, and background. Mark the appropriate rating.

   For rates of "below average", please explain in the comment box below.

Criteria	No Information	Excellent	Above Average	Average	Below Average
Medical/Clinical Knowledge					
Technical/Clinical Skills					
Clinical Judgement					
Interpersonal Skills					
System-Based Practice					
Ability to work with Others					
Ethical Conduct/Responsibility					
Sensitivity to Diversity					
Thorough, Accurate Documentation					
Communication Skills					
Professionalism					

Comments:

_____

_____

_____

4. Have you ever received any complaints concerning this applicant? ☐Yes ☐No

   If yes, please explain:_____

   _____

5. Are you (or will you become) or have you been related to or associated with the applicant as a family member or through a professional association such as a professional partnership or other financial association?

   ☐Yes ☐No

   If yes, please explain:_____

   _____

6. Are you aware of any past or present performance issues or disciplinary actions? ☐Yes ☐No

   If yes, please explain:_____

   _____

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

8. 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:_____

   _____

9. If you have additional professional practice information for consideration and prefer telephone contact to discuss, please check "yes" and someone will contact you directly.

   ☐Yes ☐No

   Phone Number: ( )_____

   Best Time to Contact You:_____

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

Completed forms may be returned to the Medical Staff Office via email at medicalstaffoffice@andersonhospital.org or by fax at (618) 288-2164