PROFESSIONAL RECOMMENDATION

This form is required as part of the practitioner's credentials application. All elements in the section below must be completed. The lower half of the form may be used for narrative comment. Please provide all information in your files, favorable or otherwise, so that it may be considered by the entity requesting the reference. (In the event this verification is being solicited on behalf of a health plan or other managed care organization, a privilege request form may not be included.)

Applicant Name:
Date of Birth:

Reference From: Name:
Dept:
Address:
City/St/Zip:
Facsimile:

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PRACTITIONER.

1. Date and type of services; This individual served with me as _____ from _____ (Month/Year) to _____ (Month/Year)

2. Please evaluate: (Please indicate with a check mark)

	Poor	Fair	Good	Superior
Medical/clinical/professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Communication and interpersonal skills				
Technical and clinical skills				

3. Recommendation: (Please indicate with a check mark)

Recommend highly and without reservation	
Recommend as qualified and competent	
Recommend with some reservation (explain)	
Concerns (explain)	

Explanation: _____

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

5. The above report is based on: (Please indicate with a check mark)

Close personal observation	
General impression	
A composite of evaluations	
Other	

6. If applicable, please refer to the list of privileges being requested. If you are unable to attest to this individual's competence in any requested area, please check the reason below and provide us with you comments.

_____ Competent to perform requested procedures _____ Not competent/unable to evaluate (please comment below)

Explanation: _____

7. To the best of your knowledge, does the applicant have: (if yes, please provide an explanation)
   a. Any physical condition that may affect their ability to perform essential job functions? _____ Yes _____ No
   b. Any mental condition that may affect their ability to perform essential job functions? _____ Yes _____ No

Explanation: _____

Name (Please Print): _____ Date: _____

Signature: _____ Title: _____

Please return this form to:

Hospital Services Corporation
Credentials Verification Services
PO Box 92200 Albuquerque, NM 87199-2200
Facsimile: (505) 346-0287
credentialing@nmhsc.com