



REFERENCE LETTER

Please Check One: (as applicable)

No Hospital Privileges

Not Board Certified

Allied Professional

Reference Letter for: _____

Name of Reference: _____

Please explain your relationship to the applicant _____

Hospital Name: _____ Department Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How long have you known the applicant? _____

Would you recommend this physician for participation in the network? Yes No *

To the best of your knowledge, are there any concerns relating to:

- | | | |
|--|------------------------------|-------------------------------|
| 1. professional performance | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |
| 2. judgment | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |
| 3. clinical skill | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |
| 4. competency | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |
| 5. mental or physical status | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |
| 6. any impairment related to chemical dependency | Yes <input type="checkbox"/> | No <input type="checkbox"/> * |

To the best of your knowledge, does the practitioner have any: pending or closed disciplinary actions?
Yes No *

To the best of your knowledge, does the practitioner have any: pending or closed malpractice cases?
Yes No *

* For any "No" responses, please explain: _____

Signature: _____ Date: _____

Title: _____