

Confidential Peer Evaluation

TO: _____

RE: _____

I have submitted a reappointment application to the Allied Health Staff of Covenant Health System. I've given your name as a peer reference and would appreciate your evaluation. Your response to the following questions will assist in my credentialing review. Please complete this confidential evaluation and **fax directly to Covenant Medical Staff Services at (806) 723-7146**. Covenant Medical Staff Services will maintain its confidentiality and I will not see the completed form or be given information of its content.

Number of years I have known this practitioner: _____

1. We are social friends professional associates other _____
2. Have you had the opportunity to observe the practitioner's skills and competence within the past 2 years? yes no if yes, in what capacity _____
3. In the following categories, I rate this practitioner to be:

	Very Good	Average	Fair or Poor
Current clinical competence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethical conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic medical knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. *Are you aware of any health problems including disability, emotional instability, alcohol, or drug related problems that might affect this practitioner's ability to care for patients? yes no
5. *To your knowledge, has this practitioner ever attempted procedures or provided services that were beyond his or her skill level or training? yes no
6. *In your opinion, is there any reason why he or she should not be affiliated as a _____ in _____ under direct supervision of the physician? yes no
7. *Do you have any reason to doubt his or her personal integrity, honesty or ethics? yes no
8. Is this practitioner in good physical health? yes no

*If you answered yes to questions 4, 5, 6, or 7, please explain your answer on a separate attachment.

Signature of person completing this form

Title

Date

Printed Name

(_____)_____
Contact phone number

Thank you for your prompt attention to this matter. Should you have any questions, feel free to contact Medical Staff Services, (806) 725-0566