TENNESSEE PHYSICIANS' QUALITY
VERIFICATION ORGANIZATION, LLC

***Response May Be Mailed or Faxed***
***Fax: (423) 495-1190; toll free: (877) 309-0933***

# PEER REFERENCE QUESTIONNAIRE

1st
2nd
3rd

TO:

FAX:

FROM:

RE:

The following health care professional has applied for appointment or reappointment to a health care organization client of the Tennessee Physicians' Quality Verification Organization. On his or her application you were listed as a **professional reference**.

Enclosed is a copy of an authorization to release information. This statement authorizes you to respond to the following questions and releases you from liability if certain conditions of good faith and reasonableness are observed in reporting the information. You do not need to return the authorization to release form with this reference questionnaire.

NAME: SPECIALTY:

## I. RELATIONSHIP OF REFERENCE SOURCE TO APPLICANT

1. How long have you known the applicant? _____

2. During what time period and in what capacity did you have the opportunity to directly observe the applicant's practice of his or her specialty? _____

3. Was your observation done in connection with any official professional title or position? ◯ Yes ◯ No
   If yes, what was your title? _____

4. Are you now or about to become related to the applicant as family or through a professional partnership or financial association? ◯ Yes ◯ No If yes, what is that relationship? _____

## II. ACTIONS TAKEN, CONDUCT AND HEALTH STATUS

If any of the following questions are answered "yes", please give details on a separate sheet.

| | YES | NO |
|---|---|---|
| Have you ever observed or been informed of any physical and/or mental health condition, including alcohol, substance abuse and /or dependence or other problems the applicant has or had that could impair his or her ability to perform his or her clinical duties? | ◯ | ◯ |
| To the best of your knowledge, has the applicant's medical license, clinical privileges, facility staff membership or other professional status ever been denied, challenged, suspended, revoked, modified, or voluntarily or involuntarily surrendered? | ◯ | ◯ |
| To the best of your knowledge, did this individual cause or contribute to any significant adverse or unusual patient incidents or occurrences, regardless of whether a patient was harmed by the event? | ◯ | ◯ |

**PROFESSIONAL EVALUATION OF:** _____

## III. EVALUATION

This evaluation should be based on the applicant's demonstrated performance compared to that reasonably expected of a health care professional with a similar level of training, experience and background. If you do not have knowledge to answer a particular question, please answer "no information."

| | FAVORABLE | UNFAVORABLE | NO INFORMATION |
|---|---|---|---|
| Basic medical knowledge | ◯ | ◯ | ◯ |
| Clinical competence | ◯ | ◯ | ◯ |
| Professional judgment and execution of responsibilities | ◯ | ◯ | ◯ |
| Ability to work with others | ◯ | ◯ | ◯ |
| Patient management | ◯ | ◯ | ◯ |
| Practitioner-Patient relationships | ◯ | ◯ | ◯ |
| Ability to understand, speak and write English | ◯ | ◯ | ◯ |
| Participation in Medical Staff activities | ◯ | ◯ | ◯ |
| Relationship with other professional staff | ◯ | ◯ | ◯ |
| Ethical conduct | ◯ | ◯ | ◯ |
| Systems-based practice* | ◯ | ◯ | ◯ |

* refers to a demonstrated understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care.

## IV. RECOMMENDATIONS

◯ Recommend without reservation

◯ Recommend with the following reservations

_____

_____

_____

◯ Do not recommend

My recommendation is based on:

◯ Personal observation of the applicant

◯ Knowledge of the applicant due to staff association

◯ Information obtained from the file of the applicant

What is the best time to contact you by telephone? _____ Telephone number: _____

_____ _____ _____

Signature Specialty Date

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