Professional reference questionnaire

This sample questionnaire may be adapted for use for various professional references, such as residency/fellowship director, previous healthcare affiliations (e.g., clinical service/department), listed professional references, etc.

Section 1 – completed by requesting entity
Name of reference: _____
Telephone: (_____)_____ Ext._____
E-mail: _____

Professional evaluation concerning (*applicant's full name, including any other name used*)
_____
_____

Specialties:
_____

We have received an application from the above-named individual stating that he/she (*indicate as applicable*)

___ completed a residency, internship, fellowship (*requesting entity circle as applicable*) in your institution
from __ __ / __ __ to __ __ / __ __ (MM/YY to MM/YY)

_____ was a staff member at your institution
from __ __ / __ __ to __ __ / __ __ (MM/YY to MM/YY)

___ names you as a personal reference

Reference should please check the accuracy of the information above and change/complete as appropriate

Present professional position: _____

Day phone: (_____)_____ Ext._____

My responses are based upon (*check all appropriate responses*)
___ direct observation
___ review of accumulated information and reports about the practitioner's performance

I know the applicant (*check the most correct response*)
___ very well ___ well ___ casually ___ personally ___ professionally
___ I do not personally know the applicant (*If checked, please skip the questions in I. Relationship of reference source to applicant and go directly to II. Professional knowledge, skills, and attitude*)

I. RELATIONSHIP OF REFERENCE SOURCE TO APPLICANT

1. How long have you known the applicant? _____

2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine?
_____

3. In what settings and with what frequency did you observe the applicant (e.g., office, hospital, residency program, etc., or daily, weekly, monthly, infrequently, etc.)?
_____
_____

4. Was your observation done in connection with any official professional title or position? ___ Yes ___ No

If so, please indicate the title and organization: _____

What was the applicant's title or position? _____

5. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? ___ Yes ___ No

If yes, please explain: _____
_____

II. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

If you do not have adequate knowledge to answer a particular question, please indicate NI (no information).

1. Please rate the following as Ex. (excellent); Good; Avg. (average); BA (below average); NI (no information):

	Ex.	Good	Avg.	BA	NI
Medical knowledge					
– Basic medical/clinical knowledge	___	___	___	___	___
– Knowledge in specialty	___	___	___	___	___
– Technical and clinical skills	___	___	___	___	___

	Ex.	Good	Avg.	BA	NI
Clinical judgment					
– Basic clinical judgment	___	___	___	___	___
– Availability and thoroughness of patient care	___	___	___	___	___
– Appropriate and timely use of consultants	___	___	___	___	___
– Quality/appropriateness of patient care outcomes	___	___	___	___	___
– Appropriateness of resource use (e.g., admissions, procedures, LOS, tests, etc.)	___	___	___	___	___
– Clinical pertinence and completeness of medical record documentation	___	___	___	___	___

	Ex.	Good	Avg.	BA	NI
Communication skills					
– Overall communication skills	___	___	___	___	___
– Verbal and written fluency in English	___	___	___	___	___
– Clarity/legibility of records	___	___	___	___	___
– Responsiveness to patient needs	___	___	___	___	___

	Ex.	Good	Avg.	BA	NI
Interpersonal skills					
– Ability to work with members of healthcare team	___	___	___	___	___
– Rapport with patients	___	___	___	___	___
– Rapport with families	___	___	___	___	___
– Rapport with hospital staff	___	___	___	___	___

	Ex.	Good	Avg.	BA	NI
Professionalism					
– Timely documentation of medical record	___	___	___	___	___
– Participation in medical staff organization activities	___	___	___	___	___
– Participation in continuing medical education	___	___	___	___	___
– Demonstration of ethical standards in treatment	___	___	___	___	___
– Maintenance of patient confidentiality	___	___	___	___	___
– Fulfillment of clinical ED call assignments	___	___	___	___	___

2. Upon review of the applicant's request for clinical privileges (enclosed), do you find the privileges requested to be appropriate and in keeping with your knowledge of the applicant's experience and clinical activity at your organization?
___ Yes ___ No ___ No information

3. Have you ever observed or been informed of any physical, mental, emotional, or behavioral issues that the applicant has or had that have affected or could potentially affect his/her ability to exercise all or any of the privileges requested or to perform the duties of medical staff appointment?
___ Yes ___ No ___ No information

If yes, please explain: _____
_____
_____

4. To the best of your knowledge, has the applicant's license, clinical privileges, hospital appointment, affiliation with any health-care organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?
___ Yes ___ No ___ No information

If yes, please explain: _____
_____
_____

5. Do you know of any malpractice action instituted or in process against the applicant?
___ Yes ___ No ___ No information

If yes, please explain: _____
_____
_____

III. SUMMARY

1. My recommendation concerning the specific clinical privileges requested is
___ recommend all privileges as requested by applicant
___ recommend privileges as requested by applicant with limitations as specified:
_____

___ do not recommend the following privileges:_____
_____

___ do not recommend any privileges requested by the applicant: _____
_____

2. My recommendation concerning this practitioner's application for appointment/affiliation is
___ recommend
___ recommend with reservation: _____
_____
___ do not recommend _____
_____

3. Please use this section for any additional comments, information, or recommendations that may be relevant to our decision to grant appointment/affiliation or specific clinical privileges/services to the applicant.
_____
_____
_____
_____

Print name: _____

Signature: _____ Date: _____