Cardinal Innovations Healthcare Solutions
Network Operations
Credentialing Project Support Professional
10150 Mallard Creek Road, Suite 400
Charlotte, NC 28262
FAX: 704-939-7513

Cardinal Innovations Healthcare Solutions Provider Evaluation Form

☐ Peer (Licensed Practitioner, not partner) ☐ Referring Physician or Practitioner ☐ Supervisor
☐ Chief of Department/Staff where practitioner has admitting privileges (Not partner)

Name of the Applicant: _____ Group Name: _____

The above provider is a Cardinal Innovations Healthcare Solutions network applicant. Please provide us with information concerning his/her professional qualifications. *All information submitted* will be held in strict confidence.

1. What is your specialty/credentials? _____
2. What is your relationship to the applicant? _____
3. How long have you known the applicant? _____
4. How would you rate the applicant's professional abilities?

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. How would you rate the applicant's rapport with consumers/clients?

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
7. What do you believe to be the applicant's strengths and weaknesses (if any)?

   a) Strengths: _____

   _____

   b) Weaknesses: _____

   _____
8. To your knowledge, has the applicant had any of the following:

Malpractice claim(s)?	Yes	No ☐
Problems with medical licensure, certification, or licensing boards?	Yes	No ☐
Revocation, denial, or change in hospital privileges?	Yes	No ☐
History of/or current impairment due to drugs and/or alcohol?	Yes	No ☐

   If your answer is yes to any of the above questions, please provide details.

   _____

   _____
9. Would you recommend this person as a provider for the Cardinal Innovations Healthcare Solutions network?
   ☐ Without reservation ☐ With reservation ☐ Would not recommend
10. Please provide any other information that would be helpful to us in evaluating this applicant. _____

    _____

    _____

Evaluator'sSignature: _____ Date: _____
PrintedName: _____ Telephone Number: _____
Address:

_____
Group Name Street City State Zip

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Group Name Street City State Zip