

## Professional Reference Questionnaire

Professional Evaluation re: \_\_\_\_\_ Date: \_\_\_\_\_  
Reference provided by: \_\_\_\_\_

Please answer all questions based on your personal knowledge and direct observation. Your candor will be greatly appreciated and your answers will remain confidential, except as necessary for accomplishing the licensing process.

### Relationship of Reference Source to Applicant

How long have you known the applicant?	From _____ to _____
During what time period did you have the opportunity to observe the applicant's practice of his/her specialty (if different from the above)?	From _____ to _____
Indicate method: Direct Observation _____ Peer Review _____ Referrals _____ Reputation _____	
Was your observation done in connection with any official professional title or position? (i.e., Department Chair, Residency Director, Proctor/Preceptor/Supervisor). If yes, please indicate title below: _____	

#### A. Clinical Evaluation

This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner with a similar level of training experience and background as this one. If you do not have knowledge to answer a particular question, please indicate "no information".

Basic Medical Knowledge	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Professional Judgment	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Sense of Responsibility	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Clinical Competence	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Ethical Conduct	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Patient Management	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Physician/Patient Relationships	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Relationship w/Peers and Hospital Personnel	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Communication & Rapport with Patients	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____
Ability to Understand, Speak and Write English	Unsatisfactory* _____	Marginal* _____	Satisfactory _____	No Information _____

\*Please provide your comments relating to Section A: \_\_\_\_\_

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Is there any additional information that would assist the Board in evaluating the clinical abilities and other skills of this applicant for licensure? \_\_\_\_\_

### B. Actions, Conduct & Health Status

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

To the best of your knowledge, has this applicant ever been subject to any disciplinary action, such as imposition of consultation requirements, suspension or termination?	Yes___ No___ Don't know___
Are/were such actions, listed above, in process or pending against the applicant?	Yes___ No___ Don't know___
To the best of your knowledge, has the applicant ever been under investigation by any governmental or other legal body?	Yes___ No___ Don't know___
Do you know of any malpractice actions instituted within the past two years or in process against the applicant?	Yes___ No___ Don't know___
To the best of your knowledge, does the applicant have any behavior, physical or mental condition (including dependence on drugs or alcohol) that could affect his or her exercise of clinical privileges or provision of quality, safe patient care?	Yes___ No___ Don't know___

### C. Recommendation

- ☐ Recommend without reservation
- ☐ Recommend with the following reservations

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ☐ Do not recommend

Reference provided by: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

What is the best time to contact you by telephone? \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Please return this form to: Susan E. Strout, Executive Secretary at the address atop this form.**