Physician Evaluation Form
(Example)

Date

Reference’s Name
Street Address
City, State, ZIP

RE: (Candidate Name)

VERIFICATION

The above physician has provided your name as a personal reference.

Indicate the number of years or length of time known: _____

EVALUATOR INFORMATION

Your current position/title: ____________________

Your relationship to the applicant is/was: __________

The information provided on this form was obtained from:

☐ Close personal observation in a supervisory role.

☐ A composite of written and/or verbal evaluations by others in authority.

☐ General impression from personal observation in a non-supervisory role.

☐ Other – please explain below.
**Physician Evaluation Form**  
(Example Continued)

RE: (Candidate Name)

**APPLICANT EVALUATION**  
This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience, and background.

<table>
<thead>
<tr>
<th>EVALUATION</th>
<th>1 Superior</th>
<th>2 Good</th>
<th>3 Fair</th>
<th>4 Poor</th>
<th>0 Not Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Medical &amp; Clinical Knowledge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Judgment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of Responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethical Conduct</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Stability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence in Clinical &amp; Technical Skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperativeness, Ability to Work With Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History &amp; Physical Exam Taking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Record Maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician-Patient Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to Understand, Speak &amp; Write English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship With Hospital Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation in Medical Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendance at Meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Physician Evaluation Form
(Example Continued)

RE: (Candidate Name)

CORRECTIVE ACTION

To your knowledge, during the time known to you or as documented in your hospital’s or institution’s records by others in authority:

Has this applicant ever been subject to any investigation or disciplinary action (including but not limited to the following): admonition, reprimand, suspension or termination by a licensing authority, Board of Trustees, or Medical Staff?

1. For unethical conduct       YES _____  NO _____  Unknown _____
2. For any other reason        YES _____  NO _____  Unknown _____

In your opinion, has the applicant ever shown signs of not being able to safely perform all elements and requirements of his/her clinical privileges?

       YES _____  NO _____  Unknown _____

Has/had the applicant ever interrupted his/her medical practice or been unable to perform all elements of the clinical privileges for which they have applied?

       YES _____  NO _____  Unknown _____

RECOMMENDATION(S)

Please indicate your recommendations of this applicant for appointment to the Medical Staff of (your organization):

☐ I would highly recommend this applicant without reservation.

☐ I would recommend this applicant as qualified and competent.

☐ I do not recommend this applicant.
Physician Evaluation Form  
(Example Continued)

RE: (Candidate’s Name)

COMMENTS

If needed, list any notable strength, weaknesses or any explanation of previous listed answers here:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What is the best day and time to contact you by telephone?
  DAY:______________
  TIME:______________ AM/PM

Phone Number: (____)______________

This evaluation form was completed by me personally. It is my understanding that the information provided will be used by the (Department Name) of (Organization’s Name) for (Purpose) and will be held in strict confidence.

DATE: ________________

________________________________________________________________________

Signature

________________________________________________________________________

Title

________________________________________________________________________

Print or Type Name