FAITH, HOPE AND LOVE

HOPE STREET FREE CLINIC
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PEER REFERENCE/CLINICAL COMPETENCE EVALUATION FORM

Please return the completed form directly to Hope Street Free clinic credentialing coordinator via email to credentials@hopestreetfreeclinic.org

_____ _____

Name of Applicant Organization Name

Please respond to the below questions:

1. How long have you known the applicant? _____.
2. In what capacity: _____.
3. Are you now or about to become related to the applicant as family or through a professional partnership or financial association? _____.
4. Does the practitioner have sufficient experience and current competence to practice medicine?_____.
5. Have you ever observed or informed of any physical and/or mental health condition, including alcohol, substance abuse and/or dependance or other problems the applicant has or had that could impair his or her ability to perform his or her clinical duties? _____.
6. 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 suspended? _____.
7. To the best of your knowledge, has the individual caused or contributed to any significant adverse or unusual patient incidents or occurrences, regardless of whether a patient was harmed by the event? _____.
8. Do you recommend this practitioner for clinical privileges at Hope street Free Clinic? _____.

Comments:_____
_____
_____

_____ _____ _____

Print Name Title Phone Number

_____ _____ _____

Signature Date Email Address