Provider Evaluation Form

Name of Applicant: _____

Relationship to Applicant:

☐ Peer ☐ Referring Physician ☐ Residency Program Director (MD, DO, Ph.D.) ☐ Previous Supervisor

☐ Supervising Physician ☐ Chief of Department/Staff where applicant has admitting privileges

The above provider is applying to participate in a managed care network(s). Letters of reference (LOR)/Evaluation forms from partners within the same practice will only be accepted if you attest that there is no financial conflict of interest. We also cannot accept LOR's/evaluation forms from a relative.

☐ **I attest that I have no financial Conflict of Interest nor am I a relative of the applicant.**

Please provide us with information below concerning his/her professional qualifications. All information submitted will be held in strict confidence.

Please complete all questions and use "NA" where applicable:

1. How long have you known the applicant? _____
2. How would you rate the applicant's professional abilities?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
3. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
4. How would you rate the applicant's rapport with patients?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. List any strengths and weaknesses:

   ☐ N/A **Strengths:** _____

   ☐ N/A **Weaknesses:** _____

6. 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:

   _____

7. Please provide any additional information that would be helpful to us in evaluating this applicant.

   _____

Legal Signature with Credentials: _____ **Date:** _____

Printed Name: _____ **Telephone Number:** _____

Address:

_____

Group Name **Street** **City** **State** **Zip**

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