

**Physician Evaluation Form**  
(Confidential Evaluation)

\_\_\_\_\_ (Name of Applicant)

Please complete all parts of this form. If more room is needed, use a separate sheet.

**I. VERIFICATION**

The physician was at \_\_\_\_\_,  
(Name of Institution)

from \_\_\_\_\_ to \_\_\_\_\_.

During that time the physician was \_\_\_\_\_.  
(Status in Institution)

**II. EVALUATION**

This evaluation should be based on demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience and background as this one.

DESCRIPTION	POOR	FAIR	GOOD	SUPERIOR
- Basic Knowledge				
- Professional Judgment				
- Sense of Responsibility				
- Clinical Competence				
- Technical Skills				
- Cooperativeness, Ability to work with others				
- Medical Records Accuracy				
- Patient Management				
- Physician/Patient Relationship				
- Participation in Medical Affairs				
- Relationship with Nursing Staff				

III. GENERAL IMPRESSION

My general impression of the applicant is:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\*\*\* The information provided in this form will be confidential and will not be revealed to the candidates unless you indicate so:

Yes, you may show this form to the candidate

No, do not show this form to the candidate

nms