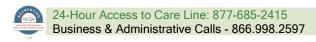




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PRACTITIONER EVALUATION FORM

r N.	ACTITIONER EVALUA	THORT ORM				
Peer (Licensed Practitioner, not partner)	Referring Physic	cian or Practitioner	Super	visor		
☐ Chief of Department/Staff where p	oractitioner has admittir	ng privileges (Not p	partner)			
Name of the Applicant:	Group 1					
The above practitioner is a Trillium Healt	•			nformation		
concerning professional qualifications.1. What is your specialty/credentic		d will be held in co	onfidence.			
What is your specially/creating What is your relationship to the control of the control						
3. How long have you known the d						
4. How would you rate the applica		 PS:				
☐ Excellent ☐ Very Good	Good	☐ Fair	iir 🔲 Poor			
5. How would you rate the applica	int's ability to work and	communicate wit	h physician and	non-physician		
staff: ☐ Excellent ☐ Very Good	Good	☐ Fair		oor		
6. How would you rate the applica				001		
☐ Excellent ☐ Very Good	Good	☐ Fair	□ F	oor		
7. What do you believe to be the o	applicant's strengths an	d weaknesses (if a	iny):			
(A) Strengths:						
(B) Weaknesses:						
8. To your knowledge, has the app	olicant had any of the fo	ollowing:				
Malpractice claim(s):		Yes	□ No			
Problems with medical licensure, certification or licensing boards:			Yes	□ No		
Revocation, denial or change in hosp			Yes	□ No		
History of/or current impairment due t	•		☐ Yes	│		
"""Ir your answer is yes	to any of the above qu	estions, piease pro	vide details.			
9. Would you recommend this per	son as a practitioner for	the Trillium Health	Resources net	work:		
☐ Without reservation ☐ With reservation ☐ Would not recommend						
10. Please provide any other inform	ation that would be hel	pful to us in evalu	ating this applic	ant:		
Evaluator's Signature	Evaluator's Printe	ed Name	Date			
Address:						
Phone #:	Email:					









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PRACTITIONER EVALUATION FORM							
Peer (Licensed Practitioner, not partner)	Referring Physic	ian or Practition	er 🗌 Superv	risor			
☐ Chief of Department/Staff where practitioner has admitting privileges (Not partner)							
Name of the Applicant: Group Name:							
The above practitioner is a Trillium Health Resources network applicant. Please provide us with information							
concerning professional qualifications. All information submitted will be held in confidence.							
What is your specialty/credentials:							
2. What is your relationship to the applicant:							
3. How long have you known the applicant:							
4. How would you rate the applicant's professional abilities:							
Excellent Very Good	Good	☐ Fair		oor			
5. How would you rate the applicant's ability to work and communicate with physician and non-physician staff:							
☐ Excellent ☐ Very Good	Good	☐ Fair	□ P	oor			
6. How would you rate the applica	nt's rapport with memb	ers:					
☐ Excellent ☐ Very Good	☐ Good	☐ Fair	□ P	oor			
7. What do you believe to be the applicant's strengths and weaknesses (if any):							
(A) Strengths:							
(B) Weaknesses:							
8. To your knowledge, has the app	licant had any of the fo	llowing:		_			
Malpractice claim(s):			☐ Yes	□ No			
Problems with medical licensure, certif	fication or licensing bo	ards:	☐ 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	o any of the above qu	estions, please pi	ovide details.				
9. Would you recommend this person as a practitioner for the Trillium Health Resources network:							
☐ Without reservation	☐ With reservation	n 🔲 Would no	t recommend				
10. Please provide any other information that would be helpful to us in evaluating this applicant:							
			-				
Evaluator's Signature	Evaluator's Printe	d Name	Date				
Address:							
Phone #:	Email:						



