Transforming Lives

Trillium HEALTH RESOURCES

Email: Credentialing@TrilliumNC.org

PRACTITIONER EVALUATION FORM

☐ Peer (Licensed Practitioner, not partner) ☐ Referring Physician or Practitioner ☐ Supervisor

☐ 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.

1. **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 ☐ Poor

5. **How would you rate the applicant's ability to work and communicate with physician and non-physician staff:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

6. **How would you rate the applicant's rapport with members:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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 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.****

9. **Would you recommend this person as a practitioner for the Trillium Health Resources network:**

☐ Without reservation ☐ With reservation ☐ Would not recommend

10. **Please provide any other information that would be helpful to us in evaluating this applicant:**

Evaluator's Signature	*Evaluator's Printed Name*	*Date*

Address:

Phone #:	Email:

Transforming Lives

Trillium HEALTH RESOURCES

Email: Credentialing@TrilliumNC.org

PRACTITIONER EVALUATION FORM

☐ Peer (Licensed Practitioner, not partner)	☐ Referring Physician or Practitioner	☐ Supervisor
☐ 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.

11. What is your specialty/credentials:

12. What is your relationship to the applicant:

13. How long have you known the applicant:

14. How would you rate the applicant's professional abilities:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

15. How would you rate the applicant's ability to work and communicate with physician and non-physician staff:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

16. How would you rate the applicant's rapport with members:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What do you believe to be the applicant's strengths and weaknesses *(if any)* :

(C) Strengths:

(D) Weaknesses:

18. 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.****

19. Would you recommend this person as a practitioner for the Trillium Health Resources network:

☐ Without reservation ☐ With reservation ☐ Would not recommend

20. Please provide any other information that would be helpful to us in evaluating this applicant:

Evaluator's Signature	*Evaluator's Printed Name*	*Date*
Address:		
Phone #:	Email:	