

Obbrooke
MEDICAL CENTER

Date: _____
Disciplinary Inquiries
Federation of State Medical Boards
[Fill in current address]
Attention: Board Action Data Bank Services Coordinator
Re: [Applicant's full name]

Date of birth _____
Medical school _____
Year of graduation _____
Social Security number _____

Dear Board Action Data Bank Services Coordinator:
Enclosed you will find our request to conduct a disciplinary action search to verify the license status of the above-referenced physician.
Thank you for your assistance with this matter.

Executive Officer

The CRC's Top Credentialing Letters

A MEDICAL STAFF OFFICE LIBRARY

Beverly E. Pybus, CPMSM



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SECTION 1

Initial Appointment

This section provides letters for initial appointment: requesting profiles from the American Medical Association; verifying state licensure, professional references, hospital affiliations, training, and education; and communicating denial or approval of privileges.

Section 1

| | |
|---|---|
|  <p>LETTER 1.1</p> | <h1>Request for AMA Physician Masterfile Profile</h1> |
|---|---|

Please note: To use the AMA Physician Masterfile Profile service you must sign an AMA Profile Order Form and Request Agreement for Physician Profile Data from the Physician Masterfile, (Form DR-505) and either pay by credit card or set up an account. You may access this information from the AMA Web site, www.profiles.ama-assn.org/amaprofiles/info/deliveryOptions.jsp.

The fees for this service are also set forth on this Web site. Online same day service is \$29/profile for one or two profiles. Multiple profiles are at a reduced rate. Mail delivery of profiles may take up to two weeks and the fee is \$29 per profile.

[Date]

American Medical Association
75 Remittance Drive Suite #6397
Chicago, IL 60675-6397

To Whom It May Concern:

The enclosed is a list of practitioner(s) who have applied for medical staff appointment and clinical privileges at this hospital.

In accordance with our credentialing procedures, we request a profile from the data bank for each practitioner listed. A duly executed release form completed for each practitioner listed is enclosed. Thank you for your assistance.

Sincerely,

Manager, Credentialing Services
Enclosure

LETTER

1.2

Request for American Osteopathic Association official profile

Please note: There is a fee for obtaining osteopathic physicians' official profiles. You can access this information at www.doprofiles.org/help/sample_profile.cfm. The fee for a paper profile is currently \$22 each and, for a faxed profile, \$25 each.

[Date]

Profile Services
American Osteopathic Association
8th Floor 142 E. Ontario Street
Chicago, IL 60611-2864

To Whom It May Concern:

The practitioner below has applied for medical staff appointment and clinical privileges at this hospital.

Practitioner's name and other name used (if applicable):

Social security number:

Address:

Date of birth:

Graduation date:

School:

In accordance with our credentialing procedures, we request a profile from the data bank regarding this practitioner. A duly executed release form is enclosed.

Thank you for your assistance.

Sincerely,

Manager, Credentialing Services

Enclosure

Section 1

| | |
|---|---|
|  <p>LETTER 1.3</p> | <h2 style="text-align: center;">Verification from Federation of State Medical Boards</h2> |
|---|---|

Disciplinary Action Data Bank
Federation of State Medical Boards of the United States
400 Fuller Wise Road Suite 300
Euless, TX 76039-3855

Re: [Practitioner's name, including any other name(s) used]

Social security number:

Date of birth:

School:

Graduation date:

ECFMG #: _____

To Whom It May Concern:

Please conduct a disciplinary action search on the above-referenced physician. Please send the results to:

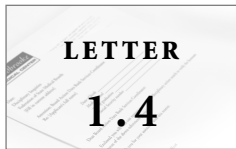
[Hospital name][Address] [City, State, Zip]Attn: [Hospital contact name and title]

Also enclosed is a copy of a signed release and immunity statement. This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides the requested information.

Thank you for your cooperation.

Sincerely,

Manager, Credentialing Services
Enclosure

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|---|----------------------------------|
|  The graphic contains the text "LETTER" in a bold, sans-serif font above the number "1.4" in a larger, bold, sans-serif font. The background of the graphic is a light gray with a faint, repeating pattern of the word "LETTER" and the number "1.4". | <h2>Verification of license</h2> |
|---|----------------------------------|

[Date]

Note: The name of the physician licensing board may vary from state to state.

Executive Director
Board of Registration in Medicine
Address

Re: [Name of Physician]

State:

Type of license:

License #:

Dear Sir/Madam:

The above-named practitioner has applied for reappointment to the [hospital name] medical staff and for continuation of clinical privileges.

The application indicates licensure in your jurisdiction as described above. We would appreciate your verifying this license and providing us with other specific information regarding the applicant. To do so, please complete the attached form and return it to us in the enclosed envelope. A prompt and full reply will be appreciated.

Also enclosed is a copy of a signed release and immunity statement. This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides the requested information.

Thank you for your cooperation.

Sincerely,

Manager, Credentialing Services
Enclosures

Section 1

| | |
|---|---|
|  LETTER 1.5 | Verification of state licensure and disciplinary proceedings |
|---|---|

RE: [Practitioner's name and other name(s) used]

State:

Type of license:

License #:

To Whom It May Concern:

The above-named practitioner has applied for medical staff appointment at this hospital. The practitioner's application indicates licensure in your jurisdiction as described above. Please verify this information and provide us with any additional information you have regarding the applicant. Please complete the attached form and return it to us in the enclosed envelope at your earliest convenience.

Also enclosed is a copy of a signed release and immunity statement. This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides the requested information.

Thank you for your cooperation.

Sincerely,

Manager, Credentialing Services

Enclosures

| | |
|---|---|
|  LETTER 1.6 | State licensure and disciplinary proceedings questionnaire |
|---|---|

RE: [Practitioner’s name (including any other names used)]:

State:

Type of license:

License number:

Date issued:

Expiration date:

If any of the following questions are answered “Yes,” please provide full details on a separate sheet.

1. Has the practitioner ever voluntarily relinquished or limited his/her license to practice?
 Yes No
2. Has the licensing authority revoked, suspended, reduced, limited, made probationary, or not renewed the practitioner’s license?
 Yes No
3. Has any proceeding been initiated by the licensing authority or other agency that could have resulted in any of the actions indicated in question #2, or is any such proceeding pending?
 Yes No
4. Has any institution, practitioner, or other entity or agency reported professional sanctions against the practitioner or other actions that may be pertinent to our credentialing process?
 Yes No
5. Has any entity reported to you that it made a payment for the benefit of the practitioner in settlement (or partial settlement) of or in satisfaction of a judgment in a medical malpractice action or claim?
 Yes No

Verified and completed by:

Name (Type or print):

Title:

Signature:

Date:

Return to: [Name of contact, address]

Attn:[**Manager, CredentialingServices**]

Section 1



[Date]

Federation of Podiatric Medical Boards
PO Box 33285
Washington, DC 20003

RE: [Practitioner's name (including any other names used)]

Address:

Date of birth:

Social security number:

Podiatry school of graduation:

Graduation date:

To Whom It May Concern:

The above-referenced practitioner has applied for medical staff membership and clinical privileges at this hospital.

In accordance with our credentialing procedures, please search your files for any information regarding the practitioner's licensure and controlled substance registration. Enclosed is a signed release statement and return envelope for your convenience.

Thank you for your assistance.

Sincerely,

Manager, Credentialing Services
Enclosure

| | |
|---|---|
|  The graphic contains the text "LETTER" in a bold, sans-serif font above the number "1.8" in a larger, bold, sans-serif font. The background of the graphic is a light gray with a faint, repeating pattern of the word "LETTER" and the number "1.8". | <h2>Verification of board certification status</h2> |
|---|---|

[Date]

Executive Director

[Board name]

[Address]

[City, State, ZIP code]

RE: Practitioner's name, including any other name(s) used:

Social security number:

Date of birth:

Specialty:

To Whom It May Concern:

The above-referenced practitioner has applied for medical staff appointment and clinical privileges at [hospital name].

The practitioner's application indicates that he/she is currently certified by your board, or is actively in the examination process leading to certification/recertification.

Please verify this information by completing the attached statement, or by providing the equivalent information on your own form, and returning it to us in the enclosed envelope at your earliest convenience.

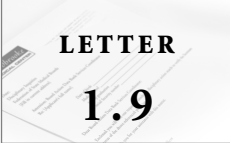
Also enclosed is a copy of a signed release and immunity statement. This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides this information.

Sincerely,

Manager, Credentialing Services

Enclosures

Section 1

| | |
|--|--|
|  The icon shows a document with the text 'LETTER 1.9' overlaid on it. <p>LETTER 1.9</p> | <h1>Letter accompanying application package and privilege request forms</h1> |
|--|--|

[Date]

Dear Dr. [name]:

I am pleased to provide you with the enclosed medical staff application and clinical privileges request forms. Please read all instructions carefully, complete the application and forms, and return them to me at your convenience. You will also find enclosed a copy of our medical staff bylaws and rules and regulations. These bylaws and rules are important, as they outline medical staff appointee, hospital, and entire staff responsibilities. You will also find the specific criteria [hospital name] uses to review your application and requests for specific clinical privileges.

Your application will be considered and processed after we receive all requested information as well as the \$200 application fee. Please note that the application for appointment must be typewritten.

Once again, please feel free to contact our medical staff office at [telephone number], or chief of staff, [telephone number], for any assistance you might require.

Sincerely,

Chief Executive Officer

Enclosures

LETTER
1.10

Letter accompanying professional reference questionnaire

[Date]

Practitioner's name (including any other name(s) used):

Date of birth:

Specialty:

The above-named practitioner has applied for medical staff appointment and clinical privileges at [hospital name]. The applicant listed you as a reference.

Based on your personal knowledge of the applicant, we would appreciate your candid, written appraisal of him or her. The enclosed professional reference questionnaire encompasses clinical ability, ethical character, ability to work cooperatively with others, health status, and other information relevant to this practitioner's qualifications for appointment and privileges.

We appreciate you providing your knowledge of these matters with respect to the applicant, particularly anything that warrants caution in granting him or her appointment or particular clinical privileges. A copy of his/her request for clinical privileges is attached so that you may assess the appropriateness of the privileges for which he/she has applied.

A self-addressed envelope is enclosed for your convenience. Your prompt and full response will be appreciated. Also enclosed is a copy of a release and immunity statement executed by the practitioner in connection with the application. This signed statement constitutes a consent to this inquiry and to your response, and releases from liability any individual who provides the requested information to representatives of this hospital.

Thank you for your cooperation.

Sincerely,

Chief Executive Officer [or Vice President of Medical Affairs]

Enclosures

Section 1

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|  <p>LETTER 1.11</p> | <h2 style="text-align: center;">Professional reference questionnaire</h2> |
|--|---|

This sample questionnaire may be adapted for use for a variety of professional references such as residency/fellowship director, previous healthcare affiliations (e.g., clinical service/department), listed professional references, etc.

Professional Reference Questionnaire

Section 1 (completed by requesting entity)

Name of reference: _____

Telephone: (____) _____ ext. _____

E-mail: _____

Professional evaluation concerning [applicant's full name, including any other name(s) used]:

Specialties:

We have received an application from the above-named individual stating he/she (indicate as applicable):

_____ completed a residency, internship, fellowship (requesting entity circle as applicable) in your institution from ___ / ___ to ___ / ___ (MM/YY to MM/YY)

_____ was a staff member at your institution from ___ / ___ to ___ / ___ (MM/YY to MM/YY)

_____ named you as a personal reference

Reference should please check the accuracy of the information above, and change or complete as appropriate

Present professional position: _____

LETTER

1.11

Professional reference questionnaire (cont.)

Day phone: (____) _____ ext. _____

My responses are based upon (check all appropriate responses)

- Direct observation
- Review of accumulated information and reports about the practitioner's performance

I know the applicant (check most correct response)

- Very well Well Casually Personally Professionally
- I do not personally know the applicant. (If checked, please skip the questions in I, Relationship of reference source to applicant, and go directly to II, Professional knowledge, skills, and attitude.)

I. Relationship of reference source to applicant

1. How long have you known the applicant? _____
2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine? _____
3. In what setting(s) and with what frequency did you observe the applicant (i.e., office, hospital, residency program, etc. or daily, weekly, monthly, infrequently)?

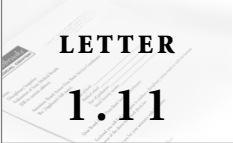
4. Was your observation done in connection with any official professional title or position? Yes No

If so, please indicate title and organization: _____

What was the applicant's title or position? _____

5. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? Yes No

Section 1

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|  | <h2 style="margin: 0;">Professional reference questionnaire (cont.)</h2> |
|---|--|

If yes, please explain: _____

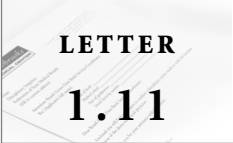
II. Professional knowledge, skills, and attitude

If you do not have adequate knowledge to answer a particular question, please indicate NI (No Information).

1. Please rate the following as Ex. (Excellent); Good; Avg. (Average); BA (Below Average); NI (No Information):

| | Ex. | Good | Avg. | BA | NI |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Medical knowledge | | | | | |
| Basic medical/clinical knowledge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Knowledge in specialty | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Technical and clinical skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Ex. | Good | Avg. | BA | NI |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Clinical judgment | | | | | |
| Basic clinical judgment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Availability and thoroughness of patient care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appropriate and timely use of consultants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Quality/appropriateness of patient care outcomes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appropriateness of resource use (admissions, procedures, LOS, tests, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Clinical pertinence and completeness of medical record documentation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|---|--|
|  | <h2 style="margin: 0;">Professional reference questionnaire (cont.)</h2> |
|---|--|

| | Ex. | Good | Avg. | BA | NI |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Communication skills | | | | | |
| Overall communication skills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Verbal and written fluency in English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Clarity/legibility of records | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Responsiveness to patient needs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Ex. | Good | Avg. | BA | NI |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Interpersonal skills | | | | | |
| Ability to work with members of healthcare team | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapport with patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapport with families | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapport with hospital staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | Ex. | Good | Avg. | BA | NI |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Professionalism | | | | | |
| Timely documentation of medical record | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Participation in medical staff organization activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Participation in continuing medical education | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Demonstration of ethical standards in treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maintenance of patient confidentiality | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fulfillment of clinical ED call assignments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|--|---|
|  <p>LETTER 1.11</p> | <h2 style="text-align: center;">Professional reference questionnaire (cont.)</h2> |
|--|---|

2. Upon review of the applicant’s request for clinical privileges (enclosed), do you find the privileges requested to be appropriate and in keeping with your knowledge of the applicant’s experience and clinical activity at your organization?

Yes No No information

3. Have you ever observed or been informed of any physical, mental, emotional, or behavioral issues that the applicant has or had that have or could potentially affect his or her ability to exercise all or any of the privileges requested or to perform the duties of medical staff appointment?

Yes No No information

If yes, please explain: _____

4. To the best of your knowledge, has the applicant’s license, clinical privileges, hospital appointment, affiliation with any healthcare organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?

Yes No No information

If yes, please explain: _____

5. Do you know of any malpractice action instituted or in process against the applicant?

Yes No No information

If yes, please explain: _____

| | |
|--|---|
|  <p>LETTER 1.11</p> | <h2 style="text-align: center;">Professional reference questionnaire (cont.)</h2> |
|--|---|

III. Summary

My recommendation concerning the specific clinical privileges requested is:

Recommend all privileges as requested by applicant

Recommend privileges as requested by applicant with limitations as specified:

Do not recommend the following privileges: _____

Do not recommend any privileges requested by the applicant: _____

My recommendation concerning this practitioner's application for appointment/affiliation is:

Recommend

Recommend with reservation: _____

Do not recommend _____

Please use this section for any additional comments, information, or recommendations that may be relevant to our decision to grant appointment/affiliation or specific clinical privileges/services to the applicant.

Print name: _____

Signature: _____ Date: _____

Section 1

| | |
|--|---|
|  <p>LETTER 1.12</p> | <h1>Verification of hospital affiliation</h1> |
|--|---|

Practitioner's name (including any other name(s) used):

Date of birth:

Dates of affiliation:

Specialty:

Dear [chief executive officer's name]:

The above-named practitioner has applied for medical staff membership in the [active/associate/courtesy/consulting] staff category and clinical privileges in the department of [name—e.g., medicine/surgery/pathology, etc.].

The application indicates affiliation with your hospital for the above stated period of time. As part of our credentialing process, we must confirm this affiliation and obtain information regarding the practitioner's performance at your institution.

Enclosed please find:

- **Release/immunity statement.** This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides the requested information.
- **Verification of hospital affiliation.** An appropriate representative of your institution should complete this verification.
- **Request for clinical privileges forms.** These forms specify the privileges requested by the applicant at this institution.
- **Practitioner performance questionnaire.** The appropriate official at your institution should complete this questionnaire.

LETTER

1.12

Verification of hospital affiliation (cont.)

In connection with the application, the practitioner has requested the privileges listed on the enclosed form(s). Please have the appropriate official review the request and complete the performance questionnaire. For the privileges/services asterisked (*), please indicate the number of procedures performed or cases of that kind treated by the practitioner at your facility during the most recent year of affiliation.

Your prompt attention to this request is appreciated.

When returning the verification statement and performance questionnaire, please include a copy of the clinical privileges the practitioner is/was authorized to provide by your organization.

Thank you for your cooperation and assistance.

Sincerely,

Chief Executive Officer

Enclosures

| | |
|--|--|
|  <p>LETTER 1.13</p> | <h2 style="text-align: center;">Release of liability form</h2> |
|--|--|

By applying for medical staff and clinical privileges at _____, I accept the terms and conditions set forth below and intend to be legally bound thereby and hereby

- signify my willingness to appear for interviews in regard to my application
- authorize the hospital, its medical staff, and its representatives to consult with my prior and current associates who may have information regarding my professional competence; ethical qualifications; ability to work cooperatively with others; other qualifications for membership and requested clinical privileges; character; and mental, emotional, and physical health status
- authorize the hospital, its medical staff, and its representatives to inspect all documents that may be material to an evaluation of my qualifications and competence, and consent to the release of such information
- release from liability all representatives of the hospital and its staff for actions performed and statements made in connection with the evaluation of my application, credentials, and qualifications to the fullest extent permitted by law
- release from liability any and all individuals and organizations who provide information to the hospital or the medical staff concerning my professional competence, background, experience, ethics, character, utilization practice patterns, and other qualifications for staff appointment and clinical privileges to the fullest extent permitted by law
- acknowledge that I have read the medical staff bylaws, and manuals and policies relevant to the application process and clinical practice at the hospital's facilities, and agree to be bound by the terms thereof in all matters
- acknowledge that medical staff bylaws provisions relating to confidentiality and release from liability are express conditions to my application for, and acceptance of, staff membership and the continuation of such membership and exercise of clinical privileges
- pledge to maintain an ethical practice, provide for continuous care for my patients, seek consultation whenever necessary, refrain from fee-splitting or other inducements related to patient referral, and

LETTER

1.13

Release of liability form (cont.)

refrain from delegating the responsibility for any aspect of patient care to any practitioner not qualified to undertake the responsibility

- agree to inform the medical staff office of any change made or proposed in the status of my professional license or permit to practice, state and federal controlled substances registrations, professional liability insurance coverage, and membership/employment/faculty status or clinical privileges at other institutions/facilities/organizations, accept committee assignments and other duties and responsibilities assigned to me by the governing board and medical staff
- acknowledge that I, as an applicant for staff membership and privileges, have the burden of producing information for a proper evaluation of my professional, ethical, and other qualifications for membership and clinical privileges
- acknowledge that I have the burden of producing information needed to resolve doubts about my qualifications
- acknowledge that medical staff reappointment and clinical privileges remain contingent upon my continued demonstration of professional competence, cooperation, support of the hospital, and acceptable performance of all related responsibilities, as well as the other factors deemed relevant by the hospital
- acknowledge that any material misrepresentation, misstatements, or omissions from this application, whether intentional or not, constitute cause for denial of appointment and clinical privileges or cause for summary dismissal from the staff

All information I've submitted in my application for medical staff appointment is true and complete to my best knowledge and belief. A photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Said photostatic copy shall have the same force and effect as the signed original.

Signature: _____

Date: _____

Section 1

| | |
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|  The graphic contains the text "LETTER" in a bold, sans-serif font at the top, and "1.14" in a larger, bold, sans-serif font below it. The background of the graphic is a light gray with a faint, repeating pattern of the word "LETTER" and the number "1.14". | <h1>Practitioner performance questionnaire</h1> |
|---|---|

Professional evaluation concerning:
Reference provided by:
Name:
M.D./other degree:
Medical specialty:
Present professional position:
Hospital/organization name and address:
Day telephone:

Responses to questions are based on:

- Personal knowledge only
- File record only
- Personal knowledge and file record

Complete Section I below if your evaluation is based in whole or in part on personal knowledge. If any question in any section is not applicable, or if you have no knowledge personally or from the file regarding it, please indicate so.

I. Relationship of source to applicant

1. How long have you known the practitioner?
2. During what time period did you have the opportunity to directly observe the practitioner's performance?
3. With what frequency did you observe the practitioner (daily, weekly, monthly, infrequently)?
4. Was your observation done in connection with any official professional title or position? If so, please indicate title?
5. Were you previously, currently, or plan to become related to the practitioner as family?
 Yes No
6. Were you previously, currently, or plan to become affiliated with the practitioner through a professional partnership or financial association?
 Yes No

LETTER

1.14

Practitioner performance questionnaire (cont.)

If you answered yes to either of the above two questions, please explain: _____

II. Professional knowledge, skills, and attitude

Before continuing, please review the practitioner's enclosed request for privileges/services and refer to the form as appropriate in answering questions in Section II.

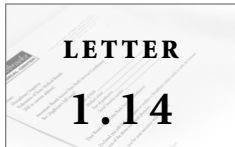
Please rate the following:

| | Satisfactory | Unsatisfactory | Don't know |
|---|--------------------------|--------------------------|--------------------------|
| a. Basic medical/clinical knowledge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Knowledge in specialty | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Clinical competence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Clinical judgment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Availability and thoroughness in patient care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Appropriate/timely use of consultants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Quality/appropriateness of care provided | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Clarity/completeness/timely medical record content | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Participation in committees, leadership | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Verbal/written fluency in English | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Rapport with patients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Ability to work with others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Were/are the privileges/services requested on the enclosed form granted to the practitioner at your institution? | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

If yes, were any specific privileges/services restricted? If yes, please explain:

If any of the requested privileges were not granted by your organization, please indicate which privilege and explain why: _____

2. Have you ever observed, or been informed, that the practitioner has or had been a habitual user of drug enforcement administration classified drugs and/or alcohol that could potentially impair his or her ability to exercise requested privilege and perform the duties of medical staff appointment?
- Yes No Don't know



Practitioner performance questionnaire (cont.)

If yes, please explain: _____

3. To the best of your knowledge, has the practitioner's license, clinical privileges, practice patterns, hospital staff appointment, or other professional status been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended (except temporary suspensions for failure to complete medical records), revoked, modified, placed on probation, or voluntarily surrendered? Do you have knowledge of any such actions that are pending?

- Yes No Don't know

If yes, or if actions were considered but the applicant resigned before the implementation of such actions, please specify:

4. Do you have knowledge of any malpractice action instituted or in process against the practitioner?

- Yes No Don't know

If yes, please explain: _____

5. To your knowledge, has the applicant ever been a defendant in a felony criminal matter?

- Yes No Don't know

If yes, what was the nature of the allegation(s)? _____

If yes, what was the finding:

- Guilty
 Pending trial or appeal
 Not guilty
 I do not know the findings

| | |
|--|---|
|  LETTER 1.14 | Practitioner performance questionnaire (cont.) |
|--|---|

III. Summary

1. Please indicate below, based on the information available to you, what your recommendation would be if the practitioner were applying for affiliation with your institution.

- Recommended, without reservation, appointment with all requested privileges
- Recommended with reservation/conditions as noted in (a) below
- Not recommend for any privileges/membership

2. Please explain any reservations or concerns regarding any specific privileges/services requested by the practitioner:

3. We appreciate your objective and forthright answers to these questions. We do ask that you provide a candid evaluation below of the applicant's clinical abilities. Additionally, please feel free to offer other comments you believe will assist us in evaluating the applicant's clinical abilities and skills.

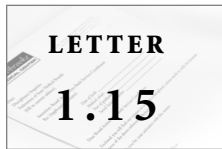
If we have any questions, what is the best time to contact you by telephone?

Telephone number: _____

Signature: _____

Date: _____

Title/position: _____

| | |
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|  The graphic contains the text "LETTER" in a bold, sans-serif font above the number "1.15" in a larger, bold, sans-serif font. The background of the graphic is a light gray with a faint, repeating pattern of the word "LETTER" and the number "1.15". | <h2>Verification of clinical privileges training</h2> |
|---|---|

[Date]

[Director of Residency or Fellowship Program]

[Address]

Re: [Applicant's name] [Dates of residency training or affiliation]

Dear [residency/fellowship director, department chair, or other]:

The purpose of this letter is to request your assistance concerning the above-named applicant's request for certain clinical privileges on our medical staff at [hospital name].

The applicant has requested clinical privileges in the following areas of clinical practice:

- [Name applicable area of practice, e.g., Internal Medicine]
- [Name applicable area of practice, e.g., Cardiology]
- [Name applicable area of practice, e.g. Interventional Cardiology]

Dr. [name] has indicated that he/she received specific, extensive training and experience in the performance of these specialty/subspecialty procedures or treatment of these illnesses while in your residency or fellowship training program.

Additionally, this applicant indicated that he/she performed the clinical privileges on the attached request form or treated patients for [name disease/condition] approximately [# as applicable] times during the last year of the training program.

LETTER

1.15

Verification of clinical privileges training (cont.)

In order for our credentials committee to appropriately evaluate his/her clinical capabilities in these areas, we request your candid assessment of this applicant's current clinical competency.

Please take a moment to respond to the following statements concerning Dr. [name].

This applicant completed this residency/fellowship program and is well known to me personally.

Yes No

While in this residency/fellowship program, this applicant did receive extensive training in the performance or treatment of the procedures or illnesses identified above.

Yes No

Based upon my observation of this applicant's performance, I personally

Recommend Recommend with reservations Do not recommend

Thank you for your cooperation and assistance.

Sincerely,

Chief Executive Officer

Section 1

| | |
|--|--|
|  LETTER 1.16 | Notification of unsatisfactory response |
|--|--|

[Date]

Dear [name],

Thank you for your response to my letter dated [date], which requested additional information and/or clarification of information in your application for medical staff appointment and clinical privileges. However, we have reviewed your response and determined that we require further information and/or clarification of information.

The following explains why your reply was deemed non-responsive, and specifies what information you must provide to adequately respond to our request:

[Insert explanation and further clarification required here.]

Please submit accurate, complete information in response to this inquiry at your earliest convenience. Your written response must be received by this office no later than [date].

We will resume processing your application once we receive a satisfactory reply from you. If we do not receive a reply by the date noted above, your application will be considered voluntarily withdrawn and your file will be closed.

Thank you for your cooperation in this matter.

Sincerely,

Chief Executive Officer

LETTER

1.17

Request for additional information, sample 1

[Date]

Dear Dr. [name]:

During the processing of your request for appointment to the medical staff of [hospital name], certain information has come to our attention that needs further clarification. On your application, you indicated that your license to practice medicine in [state] was suspended/terminated. You further indicated that the state medical board of [state] took this action due to a “minor problem concerning drug usage that was subsequently cleared up.” In order for us to continue to process your application and provide our credentials committee with complete information concerning this issue, you will need to provide this office with all correspondence concerning this issue produced by the referenced state medical board and received by you. This information includes without limitation:

- Any notification you received from the state licensing board
- Any correspondence submitted by you, your attorney, or your direct agent to the state medical board concerning this issue
- Any reports generated by other organizations, individuals, or entities addressing the issue of your past or present use of drugs
- Any other information you or our credentials committee believes relevant to the thorough and candid analysis of your licensure revocation

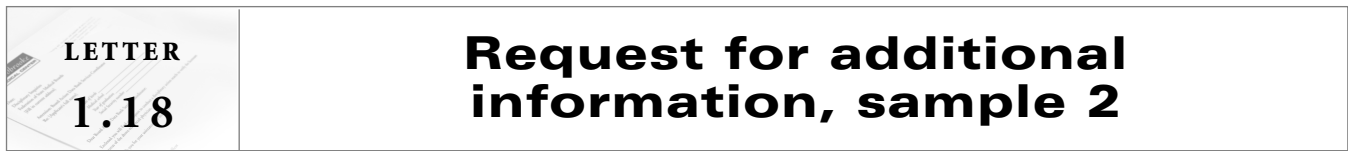
Please be advised that we will suspend further processing of your application for appointment to our medical staff until we receive the above information. The time periods for processing applications specified in [hospital name] credentialing policies and procedures will no longer be in effect for the processing of your application. Processing your application will resume as soon as we receive a satisfactory reply. If we do not receive a reply by [date], we will consider your application as voluntarily withdrawn and the file will be closed.

If you have any questions concerning this letter, please do not hesitate to contact my office at your convenience.

Sincerely,

Chief Executive Officer

Section 1



[Date]

Dear Dr. [name]:

During the processing of your request for appointment to [hospital name] medical staff, information has come to our attention that indicates you are involved in a medical staff disciplinary issue at another hospital. You indicated on your application that the issue related to “a competitive issue and did not involve the quality of patient care.”

To provide our credentials committee with complete information concerning this issue, you will need to send my office the following information:

- Any correspondence you received from the hospital pertaining to this issue
- Any correspondence you submitted to the hospital pertaining to this issue
- A copy of the fair hearing committee report (if any), or the report of any other investigating committee that convened to discuss and review this issue
- Copies of any correspondence submitted by your attorney or other agent to the hospital concerning this issue

Additionally, you indicated that you were involved in litigation in an attempt to resolve the above-referenced issue. Please provide my office with a copy of

- your complaint
- any depositions that have been taken in this case
- any reports or briefs submitted to the court concerning either defense or prosecution

Please be advised that the credentials committee will not be asked to review your application and request for privileges until the information specified above has been received. The time periods for processing applications specified in [hospital name] credentialing policies and procedures will no longer be in effect for the processing of your application. If we do not receive a reply within 15 days of the date of this letter, we will consider your application as having been voluntarily withdrawn and the file will be closed.

If you have any questions concerning this letter, please do not hesitate to contact my office at your convenience.

Sincerely,

Chief Executive Officer

LETTER

1.19

Request for physician's clinical data

[Date]

Dear Chief Executive Officer:

Dr. [name of applicant] has recently applied for appointment to the medical staff of [hospital name]. We have sent a clinical reference questionnaire to your chief of staff/residency director/department chair. The applicant has requested clinical privileges in [name of the specialties, e.g., Cardiology]. We need your assistance to evaluate this request appropriately. Please send me your hospital's report summarizing the applicant's clinical caseload (e.g., admissions, surgeries, etc.) during the past year (12-month period). If your hospital uses a medical records abstraction/processing service, the physician profile will suffice. If you maintain your own indexes, we are interested in the number, type, and general outcome of this applicant's cases. If you need additional clarification of this request, please do not hesitate to call me collect at [telephone number].

The practitioner's consent and release of liability statement is enclosed. If there is a charge for this information, please attach your invoice to your response. I would appreciate if you would complete this form and return it to my attention at your earliest convenience.

Thank you for your assistance in this important matter.

Sincerely,

Chief Executive Officer

Enclosures

Section 1

| | |
|--|--|
|  LETTER 1.20 | Notification of denial or modification of appointment request |
|--|--|

[Date]

Dear Dr. [name of applicant]:

At its meeting of [hospital name], the credentials committee recommended that your application for medical staff appointment and clinical privileges be denied or modified as follows:

[**Example:** The credentials committee recommends that appointment to the medical staff and all requested privileges be denied. The reason for the credentials committee's recommendation is as follows:

Serious unresolved concerns regarding your current clinical competence to treat complex medical conditions.]

Under the terms of our policies and the hospital's fair hearing plan (copy enclosed), you may be entitled to a review of this issue by a hearing committee.

If you would like to discuss this issue with me, I would be more than happy to meet with you.

You will soon receive a special notice concerning this issue that outlines your procedural rights to a fair hearing pursuant to the fair hearing plan.

Sincerely,

Chief Executive Officer

Enclosure

LETTER

1.21

Notification of deferral of appointment request

[Date]

Dear Dr. [applicant's name]:

At its meeting on [date], the credentials committee found it necessary to defer your request for appointment to [hospital name] medical staff. The reason for the credentials committee's action is as follows:

Example 1: Failure, on your part, to supply information demonstrating your current clinical competence

Example 2: Various discrepancies in the information you supplied as part of your application and the information we received from other sources

Example 3: Your failure to appear for your scheduled interview

With this letter, I am encouraging you to contact the credentials committee chair, at your earliest convenience, to discuss these issues. The credentials committee must, according to hospital procedures, make its report to the governing board within 30 days.

Sincerely,

Chief Executive Officer

Section 1

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|--|--|
|  LETTER 1.22 | Notification of approval of appointment and clinical privileges |
|--|--|

[Date]

Dear [applicant's name and title]:

On behalf of the board of [directors/trustees], I wish to inform you that your medical staff appointment has been approved for the following category and clinical unit(s).

Category: [staff category, e.g., Active Staff] with membership and privileges in the department(s)/section(s) of [department/section]

Clinical privileges have been granted as specified on the enclosed clinical privileges delineation forms.

Pursuant to our bylaws, you are subject to a provisional period of at least one (1) year, beginning from the date of appointment to the medical staff. Thus, this provisional period is scheduled to conclude on [date provisional period expires].

Please review our medical staff policies to familiarize yourself with the overall requirement associated with this provisional period.

It is my pleasure to welcome you to the medical staff. We look forward to a mutually rewarding relationship.

Sincerely,

Medical Staff Services Director [or Chief Executive Officer]

Enclosure: Delineation of Clinical Privileges

| | |
|---|---|
|  The graphic features the word "LETTER" in a bold, sans-serif font above the number "1.23". The background is a light gray with a faint, repeating pattern of the word "LETTER" and the number "1.23" in a smaller font, creating a textured effect. | <h2>New physician welcome and orientation letter</h2> |
|---|---|

[Date]

Dear Dr. [name]:

On behalf of the medical staff and the governing board of [hospital name], it is my pleasure to welcome you to our hospital and to our community. We are proud of our medical staff and the reputation we have as being one of the top 100 best hospitals in the country.

As we continue to expand the services our hospital offers and as a partner in our vision for the future, together we can achieve our mission to provide quality health care to the patients of our community.

Enclosed is a copy of our Physician Orientation Guide. This guide includes policies regarding

- proctoring requirements
- emergency room call coverage
- completion of medical records
- temporary privilege requests
- disruptive physicians
- leave of absence and reinstatement
- physician expectations

It also includes information on the physician's valet parking services, physician referral program, the automated dictation system, the electronic medical records system, and a map of the hospital facilities. We've also included a copy of the Medical Staff Bylaws, Rules and Regulations.

As a new member of the medical staff, you are invited to meet your fellow medical staff members at a luncheon on [insert day, date, and time] in the Physician's Dining Room directly across from the Main Dining Room. We look forward to seeing you there.

Sincerely,

Director of Medical Staff Services

Enclosures

Section 1

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|--|--|
|  LETTER 1.24 | Letter accompanying provisional status report |
|--|--|

Re: [Appointee name]

Date: [Appointment date]

Staff category: [Active, courtesy, etc.]

Department: [Name]

Section/specialty: [Name]

Dear [credentials committee chair name]:

I am pleased to report that the above-named provisional practitioner has demonstrated his/her qualifications for staff appointment and for his/her staff category. He/she has also satisfactorily demonstrated his/her ability to exercise the privileges initially granted.

The findings documented in the attached report are based upon my review of this appointee's credentials file, including a summary of activities during the provisional period and observed performance. Therefore, I recommend that his or her provisional status be concluded.

If you have any questions concerning this report or the practitioner's qualifications and clinical competence, please contact me at [phone number].

Sincerely,

Department Chair

Enclosures

LETTER

1.25

Medical student program letter

[Date]

Dear [name]:

Enclosed please find a medical student application for [hospital name] and a copy of the policy relevant to medical students in the hospital. Please complete the application and return it to the medical staff office before you begin your rotation with the [hospital name] medical staff member.

As a medical student, you will not be able to see patients until we receive a completed application, verification that you are in good standing with your program director at your school, and liability insurance by the school or by the [hospital name] staff member who is sponsoring you.

When your application is approved, you will be notified by a phone call and in writing. If you have any questions, please feel free to call me at [phone number].

Thank you for your kind attention to this matter.

Sincerely,

Manager, Medical Staff Services

Enclosures

Section 1



[Date]

Dear [practitioner name]:

Enclosed is a residency physician application to see patients in [hospital name], the policy for resident physicians, and the rules and regulations for dealing with residents in training. Please complete the application and return it to [hospital name] medical staff office.

As a resident in training, you will not be able to see patients until we receive a completed application, verification that you are in good standing in an acceptable residency program, and proof that either the program or the [hospital name] medical staff member who sponsors you is providing professional liability insurance with coverage limits in the required amount.

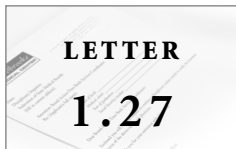
When your application is approved, you will be notified by a phone call, followed up by a letter. If you have any questions, please feel free to call me at [phone number].

Thank you for your attention to this matter.

Sincerely,

Manager, Medical Staff Services

Enclosures

| | |
|--|---|
|  LETTER 1.27 | Verification of foreign medical graduates' information |
|--|---|

[Date]

ECFMG Certification Verification Services
3624 Market Street
Philadelphia, PA 19104

Practitioner's name (including any other name[s] used):

Medical school:

Country:

Graduation date:

USMLE/ECFMG identification number:

Social security number:

Date of birth:

To Whom It May Concern:

The above-named practitioner has applied for medical staff appointment and clinical privileges at this hospital. Please complete the information on the attachment and return it to us at your earliest convenience. Also enclosed is a copy of a signed release and immunity statement. This statement constitutes consent to this inquiry and to your response, and releases from liability any individual who provides the requested information.

Thank you for your cooperation.

Sincerely,

Manager, Credentialing Services

Enclosures

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