



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
BOX 105109
FORT IRWIN, CA 92310-5109

MCXK-QI

MEMORANDUM FOR Chairman, Credentials Committee, USA MEDDAC, Fort Irwin, CA
92310-5109

SUBJECT: PEER RECOMMENDATION – Appointment/Reappointment

PROVIDER: _____

PRIVILEGES REQUESTED: _____

Any negative responses need to be further explained in the additional comments section.

1. Does the provider provide adequate documentation to support the need for admission?
____ YES ____NO ____ NA
2. Do the provider’s progress notes reflect the patient’s actual condition and need for continued hospitalization? ____ YES ____NO ____ NA
3. Does the provider document a concise admission note at the time of admission when there is to be a dictated history and physical? ____ YES ____NO ____ NA
4. Does the provider document a complete history and physical within 24 hours of admission?
____ YES ____NO ____ NA
5. Does the provider make timely and appropriate use of hospital support services (Lab, X-ray, etc.)? ____ YES ____NO ____ NA
6. Does the provider make patient rounds daily?
____ YES ____NO ____ NA
7. Does the provider demonstrate current clinical competency in your judgment?
____ YES ____NO ____ NA
8. Does the provider indicate adequate evidence to support justification for procedure(s) and/or operation(s)? ____ YES ____NO ____ NA
9. Is this provider’s operating technique adequate and competency evident?
____ YES ____NO ____ NA
10. Does the provider perform invasive procedures and/or interpretations in a satisfactory manner? ____ YES ____NO ____ NA

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11. Do the provider complete progress notes and discharge summaries as required?

_____ YES _____NO _____ NA

12. Is this provider cooperative with colleagues, nurses, and other hospital staff?

_____ YES _____NO _____ NA

13. Is the provider's behavior ethical at all times?

_____ YES _____NO _____ NA

14. Is this provider's relationship with patient(s) good?

_____ YES _____NO _____ NA

15. Does this provider abide by all the rules and regulations of the hospital and medical staff by-laws in the care of patients? _____ YES _____NO _____ NA

16. Have there been any verbal or written complaints about this provider by patients, hospital staff or members of the medical staff? _____ YES _____NO _____ NA

17. Has the provider displayed possible chemical dependency, which might affect his/her ability to perform in a competent manner? _____ YES _____NO _____ NA

18. Does the provider appear to be in good physical and mental health and exhibit no health problems that would affect his/her ability to practice in their specialty?

_____ YES _____NO _____ NA

19. I have known this provider for _____

(Please address any negative response on the reverse of his form.)

_____ Recommend without reservation:

_____ Recommend with the following reservation:

_____ Do not recommend:

Additional

Comments: _____

Date

Signature

Hospital/Agency/Organization

Printed name