SUBJECT: Letter of Recommendation

The following recommendation is provided in support of ____________________________ application for clinical privileges and/or appointment to the medical staff of Europe Regional Medical Command, Germany.

This recommendation is based on my evaluation and recommendation of the provider’s current demonstrated performance compared to that reasonably expected of a health care provider with similar level of training, experience and credentials.

EVALUATION: (please CHECK the appropriate response and address any negative responses on reverse)

NOTE: for non-physician health care providers, go to page 3.

1. Does the provider provide adequate documentation to support the need for admission?
   ___Yes   ___No   ___N/A

2. Do the provider’s progress notes reflect the patient’s actual condition and need for continued hospitalization? ___Yes ___No ___N/A

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 ___N/A

4. Does this provider document a complete history and physical within 24 hours of admission? ___Yes ___No ___N/A

5. Does the provider make patient rounds daily? ___Yes ___No ___N/A

6. Does the provider make timely and appropriate use of hospital/clinic support services (i.e., lab, x-ray, etc.)? ___Yes ___No ___N/A

7. Does the provider demonstrate current clinical competence in your judgment in the area of clinical pertinence, blood and drug utilization, infection control practices as they pertain to their specialty? ___Yes ___No ___N/A

8. Does the provider indicate adequate evidence to support justification for procedure(s) and/or operations? ___Yes ___No ___N/A
9. Is this provider’s operating technique adequate and competency evident?
   ___Yes   ___No   ___N/A

10. Does the provider perform invasive procedures, interpretations and/or FNA’s in a satisfactory manner?
    ___Yes   ___No   ___N/A

11. Does the provider complete progress notes and discharge summaries as required?
    ___Yes   ___No   ___N/A

12. Is the provider’s behavior ethical at all times? ___Yes   ___No

13. Does the provider cooperate with colleagues, nurses and other hospital staff?
    ___Yes   ___No

14. Is the provider’s relationship with patient good? ___Yes   ___No   ___N/A

15. Does the provider abide by the rules and regulations of the hospital and medical staff
    by-laws, rules and regulations in the care of patients? ___Yes   ___No

16. Have there been any substantiated verbal or written complaints about this provider by patients, hospital
    staff or members of the medical staff, to the best of your knowledge? ___Yes   ___No

17. Has the provider displayed possible chemical dependency which might affect his/her ability to perform
    in a competent manner? ___Yes   ___No

18. Does this provider appear to be in good physical and mental health and exhibits no health problems that
    would affect his/her ability to practice within their specialty? ___Yes   ___No

19. To the best of your knowledge, has this provider ever been denied membership and/or clinical
    privileges on any hospital/medical/nursing or other institution or has such action ever been recommended
    by a committee of a medical staff or governing body, hospital or
    institution? ___Yes   ___No

20. To the best of your knowledge, have there been any medical liability claims, settlements,
    judicial or administrative adjudication, or any other resolved or open charges of
    inappropriate, unethical, unprofessional or substandard professional practice?
    ___Yes   ___No
NON-PHYSICIANS ONLY - _________________________________

1. Is the provider’s behavior ethical at all times? ___Yes ___No

2. Does the provider cooperate with colleagues, nurses and other hospital staff? ___Yes ___No

3. Is the provider’s relationship with patient good? ___Yes ___No ___N/A

4. Does the provider abide by the rules and regulations of the hospital and medical staff by-laws, rules and regulations in the care of patients? ___Yes ___No

5. Have there been any substantiated verbal or written complaints about this provider by patients, hospital staff or members of the medical staff, to the best of your knowledge? ___Yes ___No

6. Has the provider displayed possible chemical dependency which might affect his/her ability to perform in a competent manner? ___Yes ___No

7. Does this provider appear to be in good physical and mental health and exhibits no health problems that would affect his/her ability to practice within their specialty? ___Yes ___No

8. To the best of your knowledge, has this provider ever been denied membership and/or clinical privileges on any hospital/medical/nursing or other institution or has such action ever been recommended by a committee of a medical staff or governing body, hospital or institution? ___Yes ___No

9. To the best of your knowledge, have there been any medical liability claims, settlements, judicial or administrative adjudication, or any other resolved or open charges of inappropriate, unethical, unprofessional or substandard professional practice? ___Yes ___No

10. Do the provider’s progress notes clearly reflect the description of the patients complaint, pertinent history, assessment and treatment plan? ___Yes ___No

11. Does the provider make timely and appropriate use of hospital/clinic support services (i.e., PAD, Legal resources for clients,)? ___Yes ___No

12. Does the provider demonstrate understanding of limits to assigned scope of practice and use sound judgment in seeking other professionals? ___Yes ___No

13. Does the provider complete progress notes, assessments, or other reports within required time-frames? ___Yes ___No
I have known this provider for _______________________ years/months.

COMMENTS: ________________________________________________________________
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____  I recommend without reservation.

____  I recommend with the following reservation(s): ______________________________
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____________________________________________________________________________
____________________________________________________________________________

____  I do not recommend for the following reason(s): _____________________________
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____________________________________________________________________________
____________________________________________________________________________

                                    ________________________________               ________________________________
Date                                                               Signature

______________________________________________________________
Please Print/Type Full Name & Position, Hospital and/or Institution Name
Telephone # where you may be reached: ____________________________