APPLICANT PEER REFERENCE FORM

Two (2) references are required for all applicants for appointment/reappointment.

Name of Applicant: _____

Specialty: _____

To Whom It May Concern:

I have submitted an application for appointment/reappointment to the staff of Valleygate Dental Surgery Centers. Please complete the information below and return it directly to the address below. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

_____

Signature Date

	YES	NO
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?		
Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?		
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?		
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?		
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?		
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?		
Does the practitioner exhibit personal integrity and adherence to professional ethics?		
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?		
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinic privileges?		

The above evaluation is based on (*check all that apply*):

- ❑ Close observation of clinical performance
- ❑ General impression
- ❑ Composite information from file
- ❑ Practitioner's reputation in the community
- ❑ Co-worker

Recommendation:

- ❑ Highly recommend without reservation
- ❑ Recommend as qualified and competent
- ❑ Recommend with reservation
- ❑ Do not recommend

Reference Information

Print Name: _____

Signature: _____

Title: _____

Fax #: _____

Date: _____

Return Form by

Mail to: Valleygate Dental Surgery Centers
ATTN: Erica Kennerson
2015 Valleygate Drive
Fayetteville, NC 28304

Email to: ekennerson@vfdental.com