

THE CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT

A department of the Naval Healthcare Support Office, Jacksonville, Florida

Professional Peer Inquiry

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

PURPOSE: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

ROUTINE USE: Information may be released to government boards or agencies or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

Provider's Name: _____, **CORPS:** _____, **USNR, SSN/DESIG:** _____

Provider's Primary Specialty: _____

The above named provider is undergoing the credentials review process within the Department of the Navy. We request your conscientious appraisal of the individual's ability to provide quality health care. Please base your evaluation on the provider's demonstrated performance compared to that reasonably expected of a provider with a similar level of training, experience and background within the past two years. Core privilege sheets identifying the provider's area of specialty and an authorization for release of information signed by the provider and a return envelope are enclosed. If this is faxed to you, please fax this completed inquiry back to CCPD at (904) 542-7210/09 promptly. Thank you.

PERSONAL INFORMATION

1. Have you worked with the provider within the past two years? _____
2. How long have you known the provider? _____
3. What is your relationship with the provider? _____

EVALUATION

If you answer "**NO**" to questions **1-11 below**, please provide an explanation on separate attached sheet

"**YES**" for Meets Community Standards "**NO**" for Does not Meet Community Standards "**UNK**" for unknown

	YES	NO	UNK
1. Professional Knowledge	_____	_____	_____
2. Practitioner/Patient Relationship	_____	_____	_____
3. Professional Judgment	_____	_____	_____
4. Practitioner-Staff Relationship	_____	_____	_____
5. Clinical Competence	_____	_____	_____
6. Practitioner-Peer Relationship	_____	_____	_____
7. Technical Skill	_____	_____	_____
8. Patient Care	_____	_____	_____
9. Quality & Completion of Health Records	_____	_____	_____
10. Participation in Medical Affairs	_____	_____	_____
11. Ethical Conduct	_____	_____	_____

If you answer "**YES**" to questions **1-5 below**, please provide an explanation on separate attached sheet.

- | | | |
|---|------------|-----------|
| 1. Have significant negative trends in the provider's clinical performance been identified? | YES | NO |
| 2. To your knowledge has the provider been investigated or had any disciplinary action taken (i.e. License suspension, limitation, revocation)? | YES | NO |
| 3. To your knowledge has the provider ever been under investigation by any governmental or other legal body? | YES | NO |
| 4. Does the provider have a physical or mental condition, which could affect his/her ability to perform professional skills or would require an accommodation in order to perform professional skills safely and competently? | YES | NO |
| 5. Is there anything that you like to discuss with us over the phone? If yes, please call (800)566-8494, x8116 or 8115. | YES | NO |

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Provider's Name: _____, **CORPS:** _____, **USNR, SSN/DESIG:** _____
Provider's Primary Specialty: _____

GENERAL IMPRESSION

My general impression of the provider is _____

RECOMMENDATION

Recommend without reservation

Recommend with reservation
(Explain on separate sheet)

Do not recommend
(Explain on separate sheet)

Printed name _____ Signature _____ Date _____

Institution _____ Position _____ Specialty _____