Cardinal Innovations Healthcare Provider Evaluation Form

☐ Peer (Licensed Practitioner, not partner) ☐ Referring Physician or Practitioner ☐ Supervisor
☐ Chief of Department/Staff where practitioner has admitting privileges (Not partner)

Name of Applicant _____ Group Name _____

The above provider is a Cardinal Innovations Healthcare network applicant. Please provide us with information concerning his/her professional qualifications. *All information submitted* will be held in strict confidence.

1. What is your specialty/credentials? _____
2. What is your relationship to the applicant? _____
3. How long have you known the applicant? _____
4. How would you rate the applicant's professional abilities?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
5. How would you rate the applicant's ability to work and communicate with physician and non-physician staff?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6. How would you rate the applicant's rapport with consumers/clients?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
7. What do you believe to be the applicant's strengths and weaknesses (if any)?
   a) Strengths: _____
   _____
   b) Weaknesses: _____
   _____
8. To your knowledge, has the applicant had any of the following:
   ☐ Yes ☐ No Malpractice claim(s)?
   ☐ Yes ☐ No Problems with medical licensure, certification, or licensing boards?
   ☐ Yes ☐ No Revocation, denial, or change in hospital privileges?
   ☐ Yes ☐ No History of/or current impairment due to drugs and/or alcohol?
   If your answer is yes to any of the above questions, please provide details.
   _____
9. Would you recommend this person as a provider for the Cardinal Innovations Healthcare network?
   ☐ Without reservation ☐ With reservation ☐ Would not recommend
10. Please provide any other information that would be helpful to us in evaluating this applicant.
    _____
    _____

Evaluator's Signature _____ Date _____
Printed Name _____ Phone _____
Complete Address _____

Cardinal Innovations HEALTHCARE