

**Credentialed Professional Staff Reference Form**

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| **Instructions to the Applicant:** | | | | | | | | | | | |
| * Please provide three confidential references and include them with the application for hospital privileges with London Health Sciences Centre (LHSC), and if applicable the academic appointment with Schulich School of Medicine & Dentistry. * References should be provided by someone who has worked, supervised, or been involved with the training/practice of the applicant for a minimum of 3-months and within the last two years and must include:   + Current Department Head or Chair of the Medical Advisory Committee in the last hospital or institution at which the applicant held an appointment or received training.     - Where an applicant was recently enrolled in a graduate training program, a reference from the Program Director of the training program is to be substituted for the reference of the Chair of the Medical Advisory Committee or Department Head. Applicants who recently completed a Fellowship may have the reference submitted in lieu to the Director by the direct Fellowship Supervisor.   + Colleague from the current or last hospital or institution at which the applicant held an appointment or received training. * References from individuals supervised by the applicant will not be accepted. | | | | | | | | | | | |
| **Instructions to Referee:** | | | | | | | | | | | |
| * Personal knowledge of the applicant is important in judging suitability for appointment and privileges. Concerns identified within the content below need to be explained. * Reference is confidential and will not be shared with the applicant. * Reference letters will **not be accepted** in lieu of this reference form. * All sections of this form must be completed. * **SUBMIT FORM TO:** [medical.affairs@lhsc.on.ca](mailto:medical.affairs@lhsc.on.ca) | | | | | | | | | | | |
| **Applicant Name:** | | | **Date of Reference:** | | | | | | | | |
| **Referee Name:** | | | **Referee Email:** | | | | | | | | |
| **Referee Title:** | | | **Referee Department:** | | | | | | | | |
| **Referee Hospital:** | | | | | | | | | | | |
| **Professional Staff Relationship to Applicant** | | | | | | | | | | | |
| 1. **Have you directly supervised the applicant in a clinical setting?** | | | | | | | **YES** | | | **NO** | |
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| 1. **How long have you worked with the applicant?** | | | | | | | | | | | |
| 1. **Describe your working relationship with the applicant (ie. colleague/supervisor) and include the name of the organization where you were acquainted at.** | | | | | | | | | | | |
| **4. Is the applicant related to you?** | | | | | | | **YES** | | | **NO** | |
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| **If the answer to question 4 above is YES, explain the relationship and whether this relationship holds a potential conflict of interest that may impact this recruitment.** | | | | | | | | | | | |
| **Leadership Skills** | | | | | | | | | | | |
| **5. Please comment on the applicant’s ability to pursue leadership roles and supervise staff.** | | | | | | | | | | | |
| **Clinical Service** | | | | | | | | | | | |
| **6. Please comment on the applicant’s clinical service contributions.** | | | | | | | | | | | |
| **Teaching Skills** | | | | | | | | | | | |
| **7. Please comment on the applicant’s Teaching contributions and their willingness to participate in teaching responsibilities and/or obligations (including Clinical and Non-Clinical Teaching).** | | | | | | | | | | | |
| **Research** | | | | | | | | | | | |
| **8. Please comment on the applicant’s Research contributions and their willingness to participate in research responsibilities and/or obligations.** | | | | | | | | | | | |
| **Clinical Administration** | | | | | | | | | | | |
| **9. Please comment on the applicant’s Clinical Administration contributions and their willingness to participate in administrative responsibilities and/or obligations (ie: serving on committees, etc.)** | | | | | | | | | | | |
| **Professional Conduct** | | | | | | | | | | | |
| ***To the best of your knowledge, please answer YES or NO to the following questions*** | | | | | | **YES** | | | **NO** | | |
| Does the applicant meet the requirements for continuing medical education? Ie. attends conferences, grand rounds, journal clubs. | | | | | |  | | |  | | |
| **If no, please explain:** | | | | | | | | | | | |
| Are you aware of any situation where the applicant has interacted inappropriately with patients or their families? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain**: | | | | | | | | | | | |
| Are you aware of any situation where the applicant has been the subject of any professional misconduct proceeding? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| Are you aware of any situation where the applicant has engaged in professional practice patterns that would endanger patient safety or welfare? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| Are you aware of any situation where the applicant’s academic appointment has been denied, suspended, revoked, modified or voluntarily surrendered? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| Are you aware of any situation where the applicant’s certificate of registration has been denied, suspended, revoked, modified, or voluntarily surrendered? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| Are you aware of any situation where the applicant’s clinical privileges have ever been denied, suspended, revoked, modified or voluntarily surrendered? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| Does the applicant have any conditions or practices that would impact  their ability to practice medicine, dentistry, midwifery or nursing? | | | | | | **YES** | | | **NO** | | |
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| **If yes, please explain:** | | | | | | | | | | | |
| **Evaluation** | | | | | | | | | | | |
| **Please place an “X” in the appropriate box that applies** | | | | **OUTSTANDING** | | **SATISFACTORY** | | **UNSATISFACTORY** | | | **NO KNOWLEDGE** |
| Ability to work with and relate to staff and leaders in a collegial and professional manner | | | |  | |  | |  | | |  |
| Ability to communicate and relate appropriately with patients and their families | | | |  | |  | |  | | |  |
| Clinical knowledge and competence | | | |  | |  | |  | | |  |
| Satisfaction of “on-call” responsibilities | | | |  | |  | |  | | |  |
| Completion of clinical record documentation | | | |  | |  | |  | | |  |
| General compliance with Public Hospitals Act, Credentialed Professional Staff By-Laws, and other relevant legislature | | | |  | |  | |  | | |  |
| Patient Management (ie. Monitoring of patients) | | | |  | |  | |  | | |  |
| Utilization of Hospital resources | | | |  | |  | |  | | |  |
| Willingness to participate in clinical, teaching and/or research responsibilities and obligations | | | |  | |  | |  | | |  |
| Ethical judgement | | | |  | |  | |  | | |  |
| **If you responded “UNSATISFACTORY” to any of the criteria above, please explain:** | | | | | | | | | | | |
| **Recommendation Summary** | | | | | | | | | | | |
| **Please place an “X” in the appropriate box that applies** | | | | | | | | | | | |
| **Recommend**  **Highly** | **Recommend** | **Recommend with reservation** | | | **Do not recommend** | | | | | | |
|  |  |  | | |  | | | | | | |
| **If you placed an “X” in “Recommend with reservation” or “Do not recommend”, please explain:** | | | | | | | | | | | |
| **Please feel free to provide any additional comments regarding the applicant.** | | | | | | | | | | | |
| **Referee Signature** | | | | | | | | | | | |
| **I confirm that the information submitted within this reference is correct to the best of my knowledge and belief.** | | | | | | | | | | | |
| **Signature:** | | **Date:** | | | | | | | | | |