APPLICANT APPRAISAL

NAME: ____________________________

1. ______________________________________ has requested credentialing in ___________________________. Please provide information relative to the scope and level of professional and clinical competence in the areas in which privileges are sought, health status and fulfillment of responsibility as a member of the health care personnel.

2. How long have you known the applicant professionally and what is your relationship?
   _____________________________________________________________

3. Staff category of applicant / grade
   _____________________________________________________________

4. Period for which applicant was granted credentialing previously (If applicable):
   From _______________ to _________________

IF THE ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PROVIDE DETAILS ON A SEPARATE SHEET.

5. Has the applicant ever been suspended, disciplined or has his/ her privileges voluntarily or involuntarily restricted or not renewed?
   ■ YES  ■ NO

6. To your knowledge, does this applicant have any existing health problems that could affect his/ her practice?
   ■ YES  ■ NO

Please provide the following information

7. The number and types of procedures performed by the applicant on record (attach separately).
   The skill and competence demonstrated in performing procedures (include information on appropriateness, outcome and the number of procedures performed)

General comments:
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
   _____________________________________________________________
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   _____________________________________________________________
8. Please complete the following assessment of the applicant’s ethical and professional qualifications. Please (✓) at the appropriate box.

<table>
<thead>
<tr>
<th></th>
<th>Above Average</th>
<th>Average</th>
<th>Below average</th>
<th>No knowledge</th>
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<tbody>
<tr>
<td>Clinical knowledge</td>
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<tr>
<td>Clinical skills</td>
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<td>Professional clinical judgement</td>
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<td>Sense of clinical responsibility</td>
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<td>Ethical conduct</td>
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<td>Cooperativeness, ability to work with others</td>
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<td>Documentation/ medical record timeliness &amp; quality</td>
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<td>Teaching skills</td>
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<td>Compliance with hospital rules &amp; regulation</td>
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OVERALL RECOMMENDATION FOR CREDENTIALING REQUESTED

☐ Recommended
☐ Not recommended

Please provide additional comments on this applicant within the framework of credentialing applied for.

COMMENTS:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

________________________
Signature

_______________________                           ___________________                          ______
Name  of HOD/ stamp                                      Phone Number                                             Date
FOR OFFICE USE

SPECIALTY SUB-COMMITTEE (SSC)

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<tr>
<th>Application Approved</th>
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<tr>
<td>For Reassessment*</td>
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<tr>
<td>Application Rejected*</td>
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*Reasons:---------------------------------------------------------------------------------------------------------------------------------
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Specialty Sub-Committee Chairman       Date
                                         Signature

NCC REFERENCE NO: ..................

NATIONAL CREDENTIALING COMMITTEE (NCC)

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*Reasons:---------------------------------------------------------------------------------------------------------------------------------
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NCC Chairman :       Date
                          Signature

NCC REFERENCE NO: ..................