NEBRASKA CREDENTIALS VERIFICATION ORGANIZATION
An Affiliate of Metro Omaha Medical Society
7906 Davenport Street, Omaha, NE 68114
Phone (402) 343-1108 800-343-5141 Fax (402) 343-0721

Date:

Name: **Email:**

Address: **Fax:**

RE:

Dear

The above referenced practitioner has applied for initial credentialing at the area entities through the Nebraska Credentials Verification Organization (NCVO), an affiliate of the Metro Omaha Medical Society and has named you as a reference on his/her application.

Please complete the "Peer Reference Questionnaire" attached and any privilege list questionnaires that are included. You do not need to return the attached privilege list(s) unless comments are made regarding specific procedures.

Then either:

1) Save the questionnaire and email it as an attachment to ncvo@omahamedical.com **OR**
2) Print it and fax to: (402) 343-0721.

A Release and Immunity Statement signed by the applicant is also included. Any further comments you may have regarding this practitioner would be appreciated on a separate sheet.

Thank you in advance for your prompt response.

Sincerely,

Credentialing Specialist

Enclosures

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REFERENCE QUESTIONNAIRE

NAME OF APPLICANT:____

REFERENCE PROVIDED BY:__________________________ **Day Phone:**____________________

Specialty:______________________________________**Title:**____________________________________

Practice Name:____

Please answer all questions based on personal knowledge and direct observation.

EVALUATION OF APPLICANT in the following areas: Medical knowledge, technical & clinical skills, clinical judgment, communication skills, interpersonal skills and professionalism	**No Concerns**	**Some Concerns****	**No Knowledge/Not applicable**
Medical/Clinical knowledge in specialty			
Clinical judgment			
Quality /Medical record completion			
Physician-Patient relationship			
Ability to understand, speak, and write English			
Technical and clinical skills			
Cooperativeness: Ability to work with others (e.g. peers, nurses, administrative staff)			
Participation in medical staff affairs			
Ethical Conduct: Clinical care, patient confidentiality, informed consent & business practice			
Sense of responsibility			
Patient management			
Analyze practice experience, evaluate outcomes & makes appropriate changes			
Practice cost-effective healthcare & resource allocation that does not compromise quality of care			

*Please explain the reason for some concerns:

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REFERENCE QUESTIONNAIRE

APPLICANT: ____

To your knowledge, has the applicant:

A. Ever been the subject of disciplinary action by a Licensing Authority, Board of Trustees or Medical Staff

For Unethical Conduct?	**YES**	**NO**	**Unknown**
For Clinical Incompetence?	**YES**	**NO**	**Unknown**
For Any Other Reason?	**YES**	**NO**	**Unknown**

B. Ever been a defendant in a felony criminal matter? **YES** **NO** **Unknown**

If yes, was the matter:	Settled out of court	Brought to Trial	
Defendant found:	Liable	Not Liable	Matter Pending

I do not know disposition:

C. Ever has been involved in malpractice action? **YES** **NO** **Unknown**

D. Health Status: Is there any reason why this practitioner would not be able to carry out the obligations and prerogatives of the medical staff membership and perform the clinical privileges s/he is requesting without exposing the practitioner or others to health and safety risks?

YES **NO** **Unknown**

If "Yes" to any question above, please explain: (Attach separate sheet if necessary)

EVALUATION INFORMATION:

Do you have direct patient care knowledge of this applicant within the last two years? YES NO

If yes, for how long?

What is/was the applicant's position/title?

RECOMMENDATION:

Recommend Do Not Recommend

Recommend with the following reservation(s):

Optional: If you would like to be contacted regarding this reference please indicate below:

Yes I would like to be contacted at ____

SIGNATURE:____DATE:________________________________

For other pertinent information, please attach a separate sheet.