PERFORMANCE ASSESSMENT

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER *(Last, First, MI)*	2. RANK/GRADE	3. SSN	4. PERIOD OF EVALUATION *(YYYYMMDD)* FROM TO

5. DEPARTMENT/SERVICE	6. SPECIALTY/AOC	7. FACILITY *(Name and Address: City/State/ZIP Code)*

8. PURPOSE OF EVALUATION

☐ Initial privileges ☐ Renewal of privileges ☐ Modification of privileges ☐ Reassignment/separation ☐ Adverse action

9. ACTIVITY DATA *(Indicate average # per month, as applicable.)* Percentage of time in providing patient care _____%

( ) Ambulatory care visits ( ) Emergency care visits ( ) Admissions ( ) Major diagnostic procedures

( ) Radiographic studies ( ) Surgical procedures ( ) Deliveries ( ) Other *(Specify)*: _____

10. IS THERE ANY ASPECT OF THE PROVIDER'S HEALTH STATUS WHICH THE CREDENTIALS COMMITTEE SHOULD CONSIDER IN AWARDING PRIVILEGES? ☐ NO ☐ YES *(Explain)*

11. IS THE PROVIDER'S ATTENDANCE AND PARTICIPATION IN PROFESSIONAL ACTIVITIES AND COMMITTEE MEETINGS ACCEPTABLE?

☐ YES ☐ NO *(Explain)*

12. ARE THE PROVIDER'S INTERPERSONAL SKILLS WITH BOTH PATIENTS AND STAFF ACCEPTABLE?

☐ YES ☐ NO *(Explain)*

13. CLINICAL PERFORMANCE PROFILE *(Provide quantitative data and explain patterns of care as demonstrated through the following functions.)*

a. ANTIBIOTIC USAGE REVIEW

b. BLOOD PRODUCTS UTILIZATION REVIEW

c. SURGICAL CASE REVIEW

d. RECORDS REVIEW

e. PHARMACY AND THERAPEUTICS REVIEW

f. MORBIDITY/MORTALITY REVIEW

g. INFECTION CONTROL

h. UTILIZATION REVIEW

i. ANCILLARY SERVICES UTILIZATION

j. OCCURRENCE SCREENING

k. RISK MANAGEMENT

l. DEPARTMENT/SERVICE SPECIFIC REVIEWS

14. REMARKS

15. PERFORMANCE EVALUATION. The following evaluation is based on this provider's demonstrated clinical performance compared to that which can reasonably be expected of a provider with his/her educational background, level of training, and experience. Check (X) the appropriate column. Any unacceptable rating must be explained below in block 16.

	ACCEPTABLE	UN-ACCEPTABLE	NOT APPLICABLE
a. Basic professional knowledge			
b. Professional judgement			
c. Professional competence			
d. Patient management skill			
(1) Outpatient			
(2) Inpatient			
(3) Operating room			
e. Written communication skills			
f. Oral communication skills			
g. Relationship with colleagues			
h. Cooperation with hospital/clinic personnel			
i. Appearance			
j. Emotional stability			
k. Sense of responsibility			
l. Professional conduct			
m. Ethical conduct			
n. Leadership capability			
o. Quality and timeliness of medical/dental record documentation			

16. COMMENTS

17a. DATE *(YYYYMMDD)*	17b. NAME OF EVALUATOR/GRADE/TITLE	17c. SIGNATURE OF EVALUATOR	17d. REVIEWED BY PROVIDER ☐ YES ☐ NO