Initial Appointment Focused Professional Practice Evaluation

NAME:

SPECIALTY:

Focused Area of Review: Five (5) review or direct observation **HOSPITAL ACTIVITY:**	***KEY: 2 = meets; 1 = partially meets; 0 = does not meet; NA = not applicable, no activity or not observed***				
Evaluate in terms of completeness, accuracy and appropriateness	**Pt #1**	**Pt #2**	**Pt #3**	**Pt #4**	**Pt #5**
Basic Medical Knowledge					
Professional Performance					
Professional Judgment					
Professional/Ethical Conduct					
Competence - Clinical Skills					
1. Assessment of Patient including, but not limited to, history and physical exams. This also includes ongoing assessment, daily rounds on patients, etc.					
2. Patient Management with the scope of delineated privileges					
3. Prescribe, initiates, monitor or alters any and all medications. Appropriately utilizes medications within the scope of practice/privileges					
4. Initiates and completes orders and order sets per policy or protocol					
Competence - Technical Skills					
1. Uses appropriate techniques for core privileges or scope of practice (i.e. insertion central lines, catheters, sutures, chest tubes, anesthesia care, etc.)					
2. Uses appropriate universal precautions including handwashing, exposure, infectious substances					

CITIZENSHIP:

Cooperativeness, ability to work with others **[ ] yes [ ] no**

Timeliness/Accuracy of documentation of Medical Records which includes progress notes, discharge summaries, etc. **[ ] yes [ ] no**

Efficiency and use of hospital resources **[ ] yes [ ] no**

Interpersonal/communication skills with patients, hospital staff, colleagues **[ ] yes [ ] no**

What are the practitioner's strengths/weaknesses?

Is there anything this practitioner needs to change to be a better practitioner?

Has this practitioner been subject to any health, substance abuse, behavioral or other problems that may affect the practitioner's performance or ability to perform the privileges requested? [ ] yes* [ ] no * Please provide explanation in the box below

Have this practitioner's clinical privileges been: a) subject to any internal focused monitoring or review? **[ ] yes [ ] no**
b) reduced/limited - either voluntarily or involuntarily? **[ ] yes [ ] no**

Evaluator Signature: _____ **Date:** _____

Clinical Service Chair Signature: _____ **Date:** _____