UNIVERSITY OF MARYLAND MEDICAL SYSTEM
MEDICAL STAFF SERVICES
110 S. Paca Street, 8th Floor
Baltimore, MD 21201
(410) 328-2902 phone (443) 462-5473 fax

EVALUATION OF ROTATOR APPLICANT

APPLICANT'S NAME: ____

HOME INSTITUION NAME: ____

The applicant named above is requesting to participate in a rotation at the University of Maryland Medical System. We are requesting your assistance in evaluating this applicant. Your knowledge of the applicant's ability and ethics are important in making an accurate appraisal. A frank, objective evaluation based upon professional considerations rather than social, casual or hearsay opinions is requested. Thank you for your cooperation.

Name of person completing evaluation: ____

Title: ____

Phone Number/E-mail address: ____

1. Dates of training with your program or institution:

   FROM: _________ TO:__________ Type of Training Program:____________________________________

2. Is the applicant currently in good standing ___ Yes ___ No (If No, please attach explanation)

3. Is this an ACGME/AOA Approved Program? ___ Yes ___ No

4. Evaluation of applicant's professional performance:

	POOR	FAIR	GOOD	SUPERIOR	INSUFFICINET KNOWLEDGE
A. Fundamental knowledge of specialty					
B. Diagnostic ability					
C. Ability to plan and execute treatment (clinical judgment)					
D. Ability to establish an effective relationship with patients					
E. Ability to establish and maintain harmonious relationship with professional personnel					
F. Motivation and capacity for sustained, effective work					
G. Judgment in recognizing his/her own duties and responsibilities in relation to his/her competency					
H. Compliance with rules and regulations, policies and procedures					

Please provide an explanation for any fair or poor ratings:

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Applicant's Name: ____

5. Are you aware of any physical or emotional health problems involving this applicant?
_______Yes _______No

6. Are you aware, either currently or in the past, of any alcohol or other chemical dependency experienced by this applicant? _______Yes _______No

7. Are you aware of any institution or medical staff considering or implementing suspension, reduction or termination of privileges or disciplinary action against this resident currently or in the past? _______Yes _______No

8. Are you aware of any malpractice complaints, settled or pending, filed against this applicant?
_______Yes ________No

9. Are you aware of any investigations or action by any state, professional society or peer review committee relating to this applicant's practice? _______Yes ________No

10. To your knowledge, has this applicant been charged with a criminal offense, or pled guilty, nolo contendere, been convicted, received probation before judgment or other diversionary disposition of any criminal act (excluding traffic violations other than impaired driving convictions, i.e., DUI, DWI)? _______Yes _______No

11. Do you have any reason to question this applicant's professional competence? _______Yes _______No

12. Are you aware of any circumstances why this applicant's participation in this program should be limited, postponed or denied? ________Yes _______No

13. Have you had any reason to question this applicant's integrity? (If yes, explain) ________Yes _______No

14. Based on your association with the applicant, can you confirm that he/she is qualified to participate in this rotation? ________Yes _______No

<u>If you answered Yes to Questions 5-13 or No to Questions 1-3 or 14, please provide an explanation here or on separate sheet.</u>

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________________ ____

Date Signature

PLEASE RETURN TO:

Evaluations should be returned to your UMMC Rotation Coordinator ONLY!
The entire packet will then be sent by the rotation coordinator to the MSO
If this evaluation is not completed the rotation will not be approved nor processed.