University of Michigan Hospitals and Health Centers

PERSONAL IDENTIFICATION & CLINICAL COMPETENCY ASSESSMENT FORM

Section 1. PERSONAL IDENTIFICATION OF APPLICANT

ATTACH CURRENT PHOTOGRAPH

Approximate Size: 2 x 2

Section 2. APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, authorize and release from liability, any hospital, licensing board, or individual who in good faith and without malice, completes the Assessment of Applicant necessary for the evaluation of my application to the Medical Staff of The University of Michigan Hospitals or submits any information concerning me to the University of Michigan Hospitals. My recent photograph is attached for verification purposes. It has been reviewed before forwarding to the Department Chairman / Chief at the hospital where I currently have an appointment.

_____ Applicant Name _____ Date

Section 3. IDENTITY CHECK BY UNIVERSITY OF MICHIGAN DEPARTMENT

☐ The identity of the applicant has been verified by a University of Michigan staff member in the appointing clinical department by viewing either a current picture hospital ID card, or a valid picture ID issued by a state or federal agency (examples: driver's license or passport).

_____ U of M Department Representative Name _____ Date

TO: DEPARTMENT CHAIR/CHIEF OR PROGRAM DIRECTOR AT CURRENT OR PREVIOUS PRIMARY HOSPITAL

Section 4. A. IDENTITY CONFIRMATION AND VERIFICATION OF COMPETENCY OF APPLICANT (observed within last 12 months) TO PERFORM REQUESTED CLINICAL PRIVILEGES AT UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS (continued on pg 2)

INSTRUCTIONS: **Please review the attached University of Michigan Hospitals privileging document/request completed by this applicant and assess the applicant's competency to perform the requested privileges by completing the information below and on Page 2 of this document.**

DEPT/DIVISION/SECTION PRIVILEGES REQUESTED	SATISFACTORY	UNSATISFACTORY (Please explain in comment section below.)	UNABLE TO EVALUATE (Please explain in comment section below.)
PLEASE SEE ATTACHED PRIVILEGING DOCUMENT	☐	☐	☐

COMMENTS:

Print Name	**Print Title (Must be Chief/Chair/Program Director)**
Print Name of Institution	**Phone Number**
Date	**Signature**

SECTION 4. B. ASSESSMENT OF APPLICANT (continued from page 1) _____

Applicant Name PRINTED

TO: **DEPARTMENT CHAIR/CHIEF OR PROGRAM DIRECTOR AT CURRENT OR PREVIOUS PRIMARY HOSPITAL**

FROM: Credentials Committee - The University of Michigan Hospitals

The above named applicant has applied for Medical Staff membership at the University of Michigan Hospitals. **Please complete the following assessment of the applicant and return it to the University of Michigan Hospitals Department where the individual is seeking privileges. The information provided will be confidential. Please contact the Office of Clinical Affairs, Medical Staff Services at (734) 647-6865 (address: 2500 Green Rd, Ste 700, Ann Arbor, MI 48105-1597) if you wish to discuss the applicant with a member of the Credentials Committee or contact the appointing Department Chairperson directly.**

The requested information will assist the appointing Department Chairperson and the Credentials Committee in evaluating the recommended appointment for medical staff membership. **PLEASE NOTE: This Assessment is a requirement for consideration of medical staff membership at the University of Michigan Hospitals.**

1. Is/Was the above named applicant in good standing on your medical staff? NO _____ YES _____
2. Dates of clinical observation covered by this form: Start Date: _____ End Date or to Present: _____
3. What is the provider's specialty/subspecialty (i.e. Vascular Surgery, Endocrinology)? : _____

IF THE ANSWER IS "YES" TO ANY OF THE QUESTIONS 5-8, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET OF PAPER.

4. Has the applicant ever been suspended, disciplined, placed on probation or had his/her privileges restricted or not renewed?
   NO _____ YES _____
5. Are you aware of any adverse actions or history with regard to this applicant's license, board certification, professional memberships, or criminal proceedings?
   NO _____ YES _____
6. To your knowledge, has this applicant ever been sued for malpractice? NO _____ YES _____
7. To your knowledge, has this applicant ever had problems with drugs, alcohol, or chemical substances?
   NO _____ YES _____

Please complete the following assessment of the applicant's moral, ethical, and professional competence	EXCEEDS STANDARDS	MEETS STANDARDS	DOES NOT MEET STANDARDS*
Basic medical/professional knowledge			
Professional judgment			
Sense of medical/professional responsibility			
Ethical conduct			
Competence and skill			
Cooperativeness, ability to work with others			
Appearance			
Record keeping			
Teaching skill			
Patient management			
Practitioner-Patient relationship			
Practitioner-Practitioner relationship			
Ability to understand and speak English			
Compliance with Hospital rules and regulations			

***If marked, please provide an explanation on a separate sheet of paper.**

OVERALL RECOMMENDATION:

- □ Recommended highly without reservation
- □ Recommended with some reservation
- □ Recommended as qualified and competent
- □ Do not recommend

If you wish to provide any additional comments regarding this individual, please do so on a separate sheet of paper and attach it to this Assessment.

The photograph on page 1 is a true likeness of the practitioner I have assessed above.

Print Name	**Print Title (Must be Chief /Chair/Program Director)**
Print Name of Institution	**Phone Number**
Date	**Signature**