I _________________________________ give permission for _________________________________ to complete the peer letter for my NYPH appointment.

The above-named clinician has applied to New York Presbyterian Hospital for an initial appointment. The practitioner has given your name as a professional who could attest to current competence and ability to perform privileges at our hospital.

**ALL QUESTIONS MUST BE ANSWERED TO ASSURE APPOINTMENT.**

How well do you know the applicant? ______ not well ___ professional acquaintance _____ very well

Please describe the nature and extent of your observation of the practitioner’s clinical performance. Hospital Office Clinic Other _____________ Daily Weekly Monthly Infrequently

Please comment on the practitioner’s professional knowledge, skills and attitude by rating the following:

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<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Unable to evaluate</th>
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<td><strong>Medical Knowledge</strong>: has good knowledge of established and evolving biomedical, clinical and cognate sciences and how to apply this knowledge to patient care.</td>
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<td><strong>Clinical Judgment</strong>: refers to the observation, perceptions, impressions, recollections, intuitions, beliefs, feelings and inference of providers.</td>
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<td><strong>Communication Skills</strong>: is able to sustain a therapeutic and ethically sound relationship with other caregivers, patients, and their families.</td>
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<td><strong>Interpersonal Skills</strong>: works effectively with other professionals.</td>
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<td><strong>Professionalism</strong>: demonstrates respect, compassion and integrity.</td>
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Health Status - Are you aware of any health issues that may have a potential effect on the applicant’s ability to perform the privileges being requested?  
Yes  
Not to my knowledge

Additional comments  _______________________________________________________________________________________

Overall recommendation (check ONE):

I recommend without reservation
I recommend with the following reservation(s)
I do not recommend this applicant for the following reason(s):

Completed by: _______________________________  Signature Date: __________________________

Print Name and title: __________________________________________________________________________

Please return the completed form within two weeks. Failure to receive the form will delay consideration of the applicant’s request for a hospital appointment. Please return to :

NewYork –Presbyterian Hospital
Graduate Medical Education Office
525 East 68th Street, Box #312
New York, NY, 10065