NAME OF APPLICANT: ____________________________

PROFESION / GRADE: ____________________________

1. __________________________________ has requested credentialing in _________________ (Name of applicant). Please provide information relative to the scope and level of professional and clinical competence in the areas in which privileges are sought, health status and fulfillment of responsibility as a member of the health care personnel.

2. How long have you known the applicant professionally?
   ………………. year ………………. month.

3. What is your relationship with the applicant?
   Please (✓) at the appropriate box.
   □ Head Of Department       □ Supervisor       □ Head of Profession
   □ Others (Please specify) …………………………………………………..

4. Has the applicant ever been suspended, disciplined or has his/ her privileges voluntarily or involuntarily restricted or not renewed?
   □ NO          □ YES (Reason …………………………………………………..

5. To your knowledge, does this applicant have any existing health problems that could affect his/ her practice?
   □ NO          □ YES (Reason …………………………………………………..

Please provide the following information

6. The number and types of procedures performed by the applicant on record (attach separately).

   The skill and competence demonstrated in performing the procedures (include information on appropriateness, outcome and the number of procedures performed)

   General comments:
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
Please complete the following assessment of the applicant's ethical and professional performance. Please (✓) at the appropriate box.

<table>
<thead>
<tr>
<th></th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>No Knowledge</th>
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</thead>
<tbody>
<tr>
<td>Clinical knowledge</td>
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<tr>
<td>Clinical skills</td>
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<td>Professional clinical judgement</td>
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<td>Sense of clinical responsibility</td>
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<td>Ethical conduct</td>
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<td>Cooperativeness, ability to work with others</td>
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<td>Documentation/medical record timeliness &amp; quality</td>
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<td>Teaching skills</td>
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<td>Compliance with institution rules &amp; regulations</td>
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OVERALL RECOMMENDATION FOR CREDENTIALING REQUESTED

- [ ] Not recommended
- [ ] Recommended

Please provide additional comments on this applicant within the framework of credentialing applied for.

COMMENTS: __________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

Tel (office): ______________________
Fax: ___________________________
Email: __________________________

______________________________
Signature

Name of Supervisor / Head Of Unit stamp

Date

Certified by Head Of Department (if applicable)

Tel (office): ______________________
Fax: ___________________________
Email: __________________________

______________________________
Signature

Name of Head Of Department stamp

Date
### SPECIALTY SUB-COMMITTEE (SSC) - ALLIED HEALTH PERSONNEL (AHP)

<table>
<thead>
<tr>
<th>Application Approved</th>
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<tbody>
<tr>
<td>For Reassessment*</td>
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<tr>
<td>Application Rejected*</td>
<td></td>
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</tbody>
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*Reasons:  
-  
-  

Specialty Sub-Committee Chairman: _______________________

Signature

Name of Chairman Of SSC stamp

SSC Reference No: ..................  Date ..................

### NATIONAL CREDENTIALING COMMITTEE (NCC)

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*Reasons:  
-  
-  

National Credentialing Committee Chairman: _______________________

Signature

Name of Chairman Of NCC stamp

NCC Reference No: ..................  Date ..................