LocumsPro

Professional Reference Form

Please complete all sections

Taken By:		**Date Taken:**	
Provider:		**Specialty:**	
Name of Reference:		**Relationship:**	
Reference Specialty:		**Time Known:**	
Recent Clinical Contact:		**Contact Frequency:**	
Institution:		**City/ State:**	
Phone:		**Email:**	

How would you describe his/ her work habits?

How adaptable is he/ she in new and different situations?

How well does he/ she know his/ her limitations?

To your knowledge, are there any problems with any sort of substance abuse?

To your knowledge, have there been any concerns and/ or disciplinary actions in regard to him/ her?

Would you send family to him/ her?

Hypothetically, would you (re)hire him/ her?

Other Comments:

Professional Reference Form

	Excellent	Good	Average	Poor	Can't Judge
Fund of Knowledge					
Professional Competency:	☐	☐	☐	☐	☐
Compared with Peers:	☐	☐	☐	☐	☐
Current Pharmacology:	☐	☐	☐	☐	☐
Clinical Judgment:	☐	☐	☐	☐	☐
Compatibility					
w/ Other Physicians:	☐	☐	☐	☐	☐
w/ Ancillary Staff:	☐	☐	☐	☐	☐
w/ Patients/ Others:	☐	☐	☐	☐	☐
Communication					
w/ Other Healthcare Staff:	☐	☐	☐	☐	☐
w/ Patients and Families:	☐	☐	☐	☐	☐
Quality of Documentation:	☐	☐	☐	☐	☐
In Stressful Situations:	☐	☐	☐	☐	☐
Other					
Integrity/ Character:	☐	☐	☐	☐	☐
Professional Appearance/ Hygiene:	☐	☐	☐	☐	☐

I affirm that all information given on this page is true and accurate.

(*Please type or print the following)*

Name: _____

Signature: _____ Date: _____