

**PEER REFERENCE FORM**

Name: \_\_\_\_\_

The above practitioner has made application for appointment to the PENN Behavioral Health Network of the University of Pennsylvania Health Systems. As part of this process, we would appreciate information requested below. The PENN Behavioral Health Credentials Committee will hold the information in confidence, and we would appreciate your complete candor in responding to this inquiry. Thank you for your prompt attention to this request.

1. How long have you known the applicant? \_\_\_\_\_
2. My knowledge of the applicant's competence is based on:  
 Personal Observation       Program Director       Colleague       Other: \_\_\_\_\_
3. Please describe your knowledge of the candidate's professional competence:

|   | Excellent | Good | Fair | Poor | No Knowledge | Comments |
|---|-----------|------|------|------|--------------|----------|
| Basic Clinical Knowledge                    |           |      |      |      |              |          |
| Professional Judgment                       |           |      |      |      |              |          |
| Competence/Skills                           |           |      |      |      |              |          |
| Sense of Responsibility                     |           |      |      |      |              |          |
| Patient Management                          |           |      |      |      |              |          |
| Provider/Patient Relationship               |           |      |      |      |              |          |
| Cooperativeness/Ability to Work with Others |           |      |      |      |              |          |

Comments : \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Return this form to: Carol Holmes  
 3535 Market St., Suite 4044  
 Philadelphia, PA 19104  
 Tel: 215-746-7906/ Fax: 215-573-6465

*Please feel free to use additional paper for Comments.*