TENNESSEE PHYSICIANS' QUALITY
VERIFICATION ORGANIZATION, LLC

Response May Be Mailed or Faxed
Fax: (423) 495-1190; toll free: (877) 309-0933

PROFESSIONAL (PEER) REFERENCE

1st

2nd

3rd

TO:

FAX:

FROM:

Re:

The following health care professional has applied for appointment or reappointment to a health care organization which is a TPQVO client. On his or her application you were listed as a professional reference.

Enclosed is a copy of a authorization to release. This statement authorizes you to respond to the following questions and releases you from liability if certain conditions of good faith and reasonableness are observed in reporting the information. You do not need to return the authorization form to us.

NAME: SPECIALTY:

How long have you known the applicant? _____

What was the applicant's title/position? _____

In what setting did you observe the applicant? _____

What was your professional title/position at that time? _____

Have you ever observed or been informed of any physical and/or mental health condition, including alcohol, substance abuse and /or dependence or other problems the applicant has or had that could impair his or her ability to perform his or her clinical duties? *Yes* ____ *No* ____

To the best of your knowledge, has the applicant's medical license, clinical privileges, facility staff membership or other professional status ever been denied, challenged, suspended, revoked, modified, or voluntarily or involuntarily surrendered? *Yes* ____ *No* ____

Please use this section to indicate any reservations, concerns, comments, information or recommendations you believe relevant to the applicant's membership and clinical privileges.

_____

_____

_____

Please check one:

____ I recommend this applicant
____ I recommend this applicant with the reservations noted above
____ I do not recommend this applicant

_____ _____ _____
Signature Specialty Date

1092 Chamberlain Avenue ♦ Suite B ♦ Chattanooga, TN 37404 ♦ (423) 495-1191 ♦ (423) 495-1190 FAX
tpqvo@tpqvo.com