Mount Sinai Health System
Medical Staff Services
Tel: (212) 824 - 8100
Fax: (212) 996-2230
MSS-Intake@mountsinai.org

Dear Doctor,

The Chair of your department at a Mount Sinai Health System is currently reviewing your file for clinical reappointment. Because of your low level of practice volume, the Chair has requested additional information in order to make an informed decision regarding your clinical competency. This request is in accordance with Joint Commission guidelines regarding medical staff reappointment. Please review the table below and provide the requested documentation that matches your current practice pattern.

The Health System may modify your clinical status/privileges based on information you provide. Low activity may result in a change to Visiting Attending, which as per the Hospital Bylaws allows you to see your patients but does not permit admitting or other privileges. If you perform consultations here within Mount Sinai Health System, which is information we do not capture, please attach a note attesting to the number performed during the last two years.

Majority of Practice is at Another Institution	**Majority of Practice is Office Based**
Need all 3 items below	**Need item 1 AND item 2**
1. One letter of Reference from a peer of your choice who can attest to your clinical ability. (See attached **Form A**)	**1.** One letter of Reference from a peer of your choice who can attest to your clinical ability. (See attached **Form A** and copy as necessary)
2. Reappointment Questionnaire which is to be completed by the Department Chairman at your Primary Institution. (See attached **Form B**)	AND
3. Summary information on volume and outcomes for the past twelve months. (See attached **Form C**)	**2.** A synopsis of your practice pattern detailing patient base, volume, procedures performed in the office, participation with managed care plans, etc. (see Attached **Form D**)
(Details of 25 patient encounters may be requested by the Department Chair)	*(Details of 25 patient encounters may be requested by the Department Chair)*

It is incumbent upon you as the applicant to ensure that the information required above is received in a timely manner by the Medical Staff Office. Your application for reappointment cannot be processed without this information and failure to provide all required documentation may impact your ability to maintain your appointment/privileges. **Documents submitted on your behalf should be sent directly to the Medical Staff Office by e-mail or fax as listed above.** If you have any questions regarding this process, please feel free to contact the Medical Staff Office.

Sincerely,

Stephan Flaim
Director, Human Resources/Medical Staff Services

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FORM A

Professional Reference Questionnaire

_____ (*Applicant Name*) is currently applying for reappointment to the Medical Staff and requests that you please complete and return this form as soon as possible in support of his/her reappointment request. If you do not have adequate knowledge to answer a particular question, please indicate "No Information." You may attach any additional information or comments you deem appropriate.

Your prompt response is greatly appreciated as any delay may impact the applicant's ability to maintain his/her privileges within Mount Sinai Health System.

Please send completed documents to the Medical Staff Office by e-mail or fax as listed above. If you have any questions regarding this process, please feel free to contact us.

Thank you.

Area	Superior	Above Average	Below Average	N/A
Teaching Ability				
Clinical Competence/Judgment				
Overall Clinical Knowledge				
Knowledge in Specialty/ Subspecialty				
Technical Skills				
Availability and Thoroughness in Patient Care				
Appropriateness and Timely Use of Consultants				
Emotional Stability				
Relationship with Peers				
Relationship with Hospital Staff				
Relationship/Rapport with Patients				
Ability to Work Well With Others				
Work Ethic				
Professional Attitude				
Overall Character				
Clarity/Completeness of Medical Records				
Medical Record Timeliness				
Legibility of Records				
Participation in Committees, Leadership, etc.				
Verbal and Written Fluency in English				
Participation in CME Activities				

_____ (*Applicant Name*)

1. How long have you known the applicant? _____

2. During what time period did you have the opportunity to directly observe the applicant's practice of medicine? _____

3. In what setting(s) and with what frequency did you observe the applicant? _____

_____

4. Was your observation done in connection with any official professional title or position?

☐ Yes ☐ No

a. If so, please indicate title and position: _____

b. What was the applicant's title or position? _____

5. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? ☐ Yes ☐ No

If yes, please explain: _____

6. Have you ever observed or been informed of any problems which the applicant has or had that have or could potentially affect his/her ability to exercise any or all of the privileges requested or to perform the duties of medical staff appointment? ☐ Yes ☐ No

If yes, please explain: _____

7. To the best of your knowledge, has the applicant's license, clinical privileges, hospital appointment, affiliation with any healthcare organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, voluntarily surrendered, or do you have knowledge of any such actions that are pending?

☐ Yes ☐ No

Summary Recommendations:

☐ I recommend without reservation for reappointment with all requested privileges

☐ I recommend for reappointment. Please note reservations on attached privileges list.

☐ I do not recommend this applicant for reappointment.

☐ I cannot comment on the clinical competence of the individual referenced above.

_____ _____

Signature Date

_____

Name (Please Print)

Attachments:

Delineation of Privileges Form

Release

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FORM B

REAPPOINTMENT QUESTIONNAIRE

To be completed by the appropriate Department Chair/Division Chief at the applicant's primary institution.

_____ (*Applicant Name*) is currently applying for reappointment to the Medical Staff and requests that you please complete and return this form as soon as possible in support of his/her reappointment request. If you do not have adequate knowledge to answer a particular question, please indicate "No Information." You may attach any additional information or comments you deem appropriate.

Your prompt response is greatly appreciated as any delay may impact the applicant's ability to maintain his/her privileges within Mount Sinai Health System.

Please send completed documents to the Medical Staff Office by e-mail or fax as listed above. If you have any questions regarding this process, please feel free to contact us.

Thank you.

Area	Superior	Average	Below Average	No Information
Teaching Ability				
Clinical Competence/Judgment				
Overall Clinical Knowledge				
Knowledge in Specialty/ Subspecialty				
Technical Skills				
Availability and Thoroughness in Patient Care				
Appropriateness and Timely Use of Consultants				
Emotional Stability				
Relationship with Peers				
Relationship with Hospital Staff				
Relationship/Rapport with Patients				
Ability to Work Well With Others				
Work Ethic				
Professional Attitude				
Overall Character				
Clarity/Completeness of Medical Records				
Medical Record Timeliness				
Legibility of Records				
Participation in Committees, Leadership, etc.				
Verbal and Written Fluency in English				
Participation in CME Activities				

_____ (*Applicant Name*)

Summary Recommendations:

☐ I recommend without reservation for reappointment with all requested privileges.

☐ I recommend for reappointment. Please note reservations on attached privileges list.

☐ I do not recommend this applicant for reappointment.

☐ I cannot comment on the clinical competence of the individual referenced above.

_____ _____

Department Chair/Division Chief Signature Date

_____

Department Chair or Division Chief Name (Please Print)

_____

Name of Organization

Attachments:
Delineation of Privileges
Release

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Form C

Majority of Practice is at Another Institution
To Be Completed By The Practitioner

The following is required for your work performed at another institution:

- Form **A** (to be completed by a Peer of your choice)
- Form **B** (to be completed by the Department Chair)

Forms **A** & **B** are to be returned to Medical Staff Services by the Institution

Please complete and return this page to the Medical Staff Office by e-mail or fax as listed above. If you have any questions regarding this process, please feel free to contact us.

Practitioner Name (Print): _____

Institution/Medical Facility: _____

Department: _____

Name of Chair: _____

Phone_____**Fax**_____

Name of Peer Reference: _____

Phone_____**Fax**_____

Information on Volume and Outcomes for the past twelve months

Patient Base and Procedures		Number of Ambulatory/ Outpatient Procedures	
Number of Surgeries		Number of Medical Records Suspensions	

(Details of 25 patient encounters may be requested by the Department Chair)

_____ _____

Practitioner's Signature **Date**

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Form D

Majority of Practice is Office Based
To Be Completed By The Practitioner

For your work performed at your Primary Office, **Form A** is to be completed by a Peer of your choice and returned by them to Medical Staff Services.

Please complete and return this page to the Medical Staff Office by e-mail or fax as listed above. If you have any questions regarding this process, please feel free to contact us.

Practitioner Name (Print): _____

Department: _____

Office Address: _____

Name of Peer Reference: _____

Phone_____**Fax**_____

Synopsis of your Practice Pattern

Patient Base & Procedures Performed _____

_____

Volume _____

Participation with managed care plans _____

_____

(Details of 25 patient encounters may be requested by the Department Chair)

_____ _____

Practitioner's Signature **Date**