

9. (PROVIDER'S NAME) IS KNOWN TO BE CLINICALLY COMPETENT TO PRACTICE THE FULL SCOPE OF PRIVILEGES GRANTED AT (SENDING FACILITY), TO SATISFACTORILY DISCHARGE HIS/HER PROFESSIONAL OBLIGATIONS, AND TO CONDUCT HIMSELF/HERSELF ETHICALLY, AS ATTESTED TO BY (NAME AND TELEPHONE NUMBER OF PERSON PERSONALLY ACQUAINTED WITH THE PROVIDER'S PROFESSIONAL AND CLINICAL PERFORMANCE). (NAME OF PERSON GIVING RECOMMENDATION) HAS/DOES NOT HAVE ADDITIONAL INFORMATION RELATING TO (PROVIDER'S NAME) COMPETENCE TO PERFORM GRANTED PRIVILEGES. [When additional information exists, the gaining facility must be instructed to communicate with the point of contact for the purpose of exchanging the additional information.]

10. PROVIDER'S CF AND THE DOCUMENTS CONTAINED THEREIN HAVE BEEN REVIEWED AND VERIFIED AS INDICATED ABOVE. THE INFORMATION CONVEYED IN THIS LETTER/MESSAGE REFLECTS CREDENTIALS STATUS AS OF (date)____. [Choose from the following sentence formats, or variations thereof, to describe the presence/absence of additional relevant information in the CF: (a) THE CF CONTAINS NO ADDITIONAL INFORMATION RELEVANT TO THE PRIVILEGING OF THE PROVIDER IN YOUR MTF, (b) THE CF CONTAINS ADDITIONAL RELEVANT INFORMATION REGARDING STATUS OF CURRENT LICENSE, (c) THE CF CONTAINS ADDITIONAL RELEVANT INFORMATION THAT MAY REFLECT ON THE CURRENT COMPETENCE OF THE PROVIDER. CONTACT THIS COMMAND FOR FURTHER INFORMATION BEFORE TAKING APPOINTING AND PRIVILEGING ACTION.]

11. POC: NAME, TITLE, PHONE NUMBER, FAX NUMBER

12. (FOR RESERVE OR GUARD HCPS) CURRENTLY HOLDS PRIVILEGES IN (SPECIALTY) AT (HOSPITAL NAME, ADDRESS). PROVIDER MAY BE REACHED AT (MAILING ADDRESS, HOME PHONE, OFFICE PHONE).

13. CERTIFIED BY:

COMMANDER

DATE