مـركـــز الـتـخـطـيــط والجـــودة لـلـخـدمــات الـطـبـيــة
CENTER FOR HEALTHCARE PLANNING & QUALITY

RECOMMENDATION FORM

Date____/____/_____

I hereby authorize the representative or staff of the facility listed below to provide all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Applicant name: ____

INSTRUCTION TO THE CHIEF OF SERVICE OR PROGRAM DIRECTOR IN YOUR FIELD: Please complete the questions below.

1. How long have you known the applicant? From ___/____/____ to ______/_____/_______

A. In what capacity? ☐ Supervisory ☐ Colleague ☐ Affiliated in Practice ☐ Other__________________

B. Date (s) of Applicant's affiliation at facility: From ___/__ _/_____ to ____/_____/______

C. Applicant's Status: ☐ Intern ☐ Resident ☐ Fellow ☐ Staff Member ☐ Other__________________

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?

☐ No ☐ Yes (If yes, please explain below)

____

____

3. Please rate the following (If "Below Average" or "Poor", explain in detail on the back of this evaluation and or attach a separate sheet:

Description	Superior	Above Average	Average	Below Average	Poor
Clinical Knowledge					
Clinical Competency					
Professional Judgment					
Character and Ethics					
Technical Skills					
Relationship with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

ص. ب ٥٠٥٠٠١، دبي، إ.ع.م، هاتف: ٥٥٥٥ ٣٢٤ ٤ ٩٧١+، فاكس: ٤٧٧٠ ٣٦٢ ٤ ٩٧١+، بريد إلكتروني: info@cpq.dhcc.ae, موقع إلكتروني: www.dhcc.ae

P.O. Box 505001, Dubai, U.A.E, Tel. +9714 324 5555, Fax +9714 362 4770, E-mail: info@cpq.dhcc.ae, Web: www.dhcc.ae

4. Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s) he resigned from the medical staff in lieu of disciplinary action? **If "Yes" please explain below**

   ☐ NO ☐ YES

   ___

   ___

5. Please comment on the dentist's/physician's strength or weakness and / or any other information that you may have to assist in this evaluation.

   ___

   ___

6. The above comments are based on the following:

   ☐ Close personal observation

   ☐ General impression

   ☐ A composite of previous evaluation by other physicians

   ☐ Other___

7. RECOMMENDATIONS:

   ☐ I recommend ___ for licensure in ___

   ☐ I recommend ___ for licensure in ___
   (With the following reservations)

   ___

   ☐ I do not recommend ___ for licensure in ___

Signature___ *(check one)* ☐ M.D ☐ D.O. ☐ Others___

Print your name ___ Date ___/___/___

Academic title or position ___ Phone Number ___

Specialty/ Service or Department ___

Please return the complete and sealed form with YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE DIRECTLY to the Center for Healthcare Planning & Quality (CPQ) to the following address:

Postal address
Licensing Department – CPQ
Dubai Healthcare City - P.O. Box 505001
Dubai, United Arab Emirates

For courier delivery:
Licensing Department - CPQ
The 4 Buildings, Block B
Dubai Healthcare City - Oud Metha Road
Dubai, United Arab Emirates
Tel: +971-4-362-2790
Fax: +971-4-362-4770

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