مركز التخطيط والجودة للخدمات الطبية
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					

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

_____

_____

ص.ب ٥٠٥٠٠١، دبي، إ.ع.م، هاتف: ٥٥٥٥ ٣٤٢ ٩٧١٤+، فاكس: ٤٧٧٠ ٣٦٢ ٩٧١٤+، بريد إلكتروني: info@cpq.dhcc.ae, موقع إلكتروني: www.dhcc.ae
P.O. Box 505001, Dubai, U.A.E, Tel. +9714 342 5555, Fax +9714 362 4770, E-mail: info@cpq.dhcc.ae, Web: www.dhcc.ae

مركز التخطيط والجودة للخدمات الطبية
CENTER FOR HEALTHCARE PLANNING & QUALITY

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_____ Email_____

Specialty/Service or Department _____

Organization/Hospital/Clinic, (name, address and stamp) _____

_____

_____

_____

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
Professional Licensing Department
Center for Healthcare Planning and Quality (CPQ)
Dubai Healthcare City
P.O. Box 505001
Dubai, United Arab Emirates

For courier delivery:
Professional Licensing Department
Center for Healthcare Planning and Quality (CPQ)
Ibn Sina Building, Block B
Dubai Healthcare City
Oud Metha Road
Dubai, United Arab Emirates
Tel: +971-4-362-2790
Fax: +971-4-362-4770