Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226
mezimmermann@mcw.edu
414-955-1195

Training Verification: COMPREHENSIVE

SECTION I: GENERAL INFORMATION

Name of practitioner:		
Name of program institution: **Medical College of Wisconsin**		
Name of training specialty:		
Program Dates **Start:** **End:**		
Did the practitioner complete the training of this program? Please Explain.	Yes	No
Is this program ACGME Accredited?	Yes	No
If 'NO', please name the educational institution in full:		
Were there any sanctions or other disciplinary action taken against this applicant during this time? Please Explain.	Yes	No
To your knowledge has the practitioner ever been under investigation by any governmental or other legal body? Please Explain.	Yes	No
Was the practitioner ever subject to any malpractice action? Please Explain.	Yes	No

Explanation(s): ____

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SECTION II: EVALUATION of Applicant in General Competencies:

Area of Competency	Meets Expectations	Needs Improvement**	Unable to Assess**
1. Medical / Clinical Knowledge in Specialty			
2. Clinical Judgment			
3. Technical and Clinical Skills			
4. Quality / Medical Record Completion			
5. Ability to Understand, Speak, and Write English			
6. Physician-Patient Relationship			
7. Patient Management			
8. Participation in Medical Staff Affairs			
9. Sense of Responsibility			
10. Ethical Conduct: clinical care, patient confidentiality, informed consent, and business practice.			
11. Cooperativeness, Ability to Work with Others (e.g. peers, nurses, administrative staff)			
12. Analyze practice experience, evaluate outcomes & makes appropriate changes			
13. Practice cost-effective healthcare & resource allocation that does not compromise quality of care			

** Please explain the reason for your evaluation to assess in the space below.
Attach a separate sheet if necessary.

My evaluation is based on:
General & Personal Observation____ File Records____ Composite of Evaluation(s)____

Competency #(s): ________________ Explanation(s): ________________________________

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SECTION III: RECOMMENDATION

A. How many years have you known the practitioner? ______________________

B. What is/was your relationship to the practitioner? ______________________

Practitioner is (please select option A, B, or C):

____ A. Recommended without reservation.

____ B. Recommended with the following reservations (please explain):

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____ C. CANNOT RECOMMEND (Please explain in detail):

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SECTION IV: CONTACT INFORMATION

<table>
<tr><td>Email/Phone:</td><td>Best time to contact you:</td></tr>
<tr><td colspan="2">Printed Name:</td></tr>
<tr><td>SIGNATURE:</td><td>DATE:</td></tr>
</table>

TITLE: Program Director ____

Associate Program Director ____

or

Other: ____ Please explain history in or associated with position:

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