

SUNY Upstate University Hospital
NEW PRIVILEGE EVALUATION (FPPE)

Name _____ Department / Division _____ Date _____

_____ Initial Privileges _____ Increase in Privilege for: _____	Excellent	Satisfactory	Below expectations	Unable to evaluate
Patient Care: Makes informed decisions and therapeutic decisions based on patient information, current scientific evidence, and clinical judgment.				
Medical/Clinical Knowledge: Knows and utilizes basic and clinical sciences, and applies knowledge to patient care.				
Practice-Based Learning and Improvement: Actively participates in the education of patients and families, students, and residents, and uses evaluations of performance to improve practice.				
Interpersonal and Communication skills: Communicates effectively with patients, families, physicians, and other health care professionals.				
Professionalism: Demonstrates respect for and responsiveness to the needs of patients and society with commitment to providing care in a compassionate and ethical manner without discrimination.				
Systems-Based Practice: Works to provide care that is safe, efficient, patient-centered, timely, and equitable.				
Method(s) of review:	Mark those used:	Please list all Medical Record numbers, and dates of care, included in the evaluation:		
1. Interdisciplinary team overview		MR#:	Dates:	
2. Chart review (prospective / retrospective): # reviewed _____		MR#	Dates:	
3. Direct / Indirect monitoring # _____		MR#	Dates:	
4. Observation		MR#	Dates:	
5. Patient Comments (positive / negative)		MR#	Dates:	
6. Verbal report by staff member being evaluated		MR#	Dates:	
7. Internal / External peer evaluation		MR#	Dates:	
8. Review at Clinical Department M & M meetings # _____		MR#	Dates:	
9. Monitoring of clinical practice patterns		MR#	Dates:	
10. Proctoring # _____		MR#	Dates:	
11. Other (Please describe):		MR#	Dates:	

_____ Based on this assessment, the practitioner reviewed appears to be functioning competently at this time.

_____ Based on this assessment, the practitioner reviewed needs further review of his or her privileges as described:

Signature of reviewer (Please sign and print): _____ Date: _____

I acknowledge that the above results of my Focused Professional Practice Evaluation were shared with me. My signature does not necessarily constitute agreement with this evaluation.

Signature of Practitioner reviewed: _____ Date: _____