St. David's South Austin Medical Center

APP Sponsor Evaluation of Privileges Form for FPPE

Form to be turned in to Medical Staff Office upon completion. Fax #816-7278.

Section I: To be completed by the Advanced Practice Professional (APP). ***Three** cases involving patient encounters related to privileges are to be submitted. Copy form as needed.

APP Name, printed:_____

SAMC Medical Record Number(s): _____

This is #_____ of three cases.

Which privileges were utilized in this case? _____

**CASES MUST BE FROM SOUH AUSTIN MEDICAL CENTER. THE JOINT COMMISSION STANDARDS DO NOT ALLOW DATA FROM OTHER FACILITIES TO BE USED.*

Section II: To be completed by physician sponsor:

Based on the information available to me, I am providing the following evaluation related to this provider's privileges practiced at St. David's South Austin Medical Center:

EVALUATION INDICATOR	SATISFACTORY	UNSATISFACTORY (If checked, provide details below in comments section)	UNABLE TO EVALUATE
Clinical Competence			
Clinical Knowledge			
Clinical Professional Judgment			
Clinical Technical Skills			
Interpersonal/Communication Skills			
Availability/Responsiveness			
Use of Consultations			
Ethical Conduct/Professionalism			
Utilization of Clinical Services			
Comments			

Completed by: _____ *(sponsor printed name)*

_____ _____

Signature of Physician Sponsor Date

Section III

RETURN THIS FORM TO THE SAMC MEDICAL STAFF OFFICE. FAX 512-816-7278