

**NEW HORIZON SURGICAL CENTER, LLC**

680 BROADWAY, SUITE 201, PATERSON, NJ 07514

TEL.: (973) 782-4202 ❖ E-FAX: (973) 807-9340

[www.NewHorizonASC.com](http://www.NewHorizonASC.com)

**PEER REFERENCE FORM**

Hello Dr. \_\_\_\_\_:

You have been requested to provide reference information for Dr. \_\_\_\_\_, an applicant for admitting privileges to New Horizon Surgical Center, LLC. Pertinent information concerning the applicant will be helpful to the Governing Body of New Horizon Surgical Center, LLC in processing his/her application for privileges.

As one of the applicant's references, you are familiar with his/her professional work and have knowledge of his/her ability, character and reputation. The Board would appreciate information that bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence in his/her medical specialty and moral character.

This form is to be completed by a physician and the recommending physician must have known the applicant for at least six (6) months. Recommending physicians are strongly urged to include additional comments. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please either mail it or fax it back to the address and fax # provided above.

Please use a separate piece of paper to clarify any area that rates unsatisfactorily.

	EXCELLENT	SATISFACTORY	UNSATISFACTORY
Moral Integrity of Applicant	_____	_____	_____
Emotional Stability of Applicant	_____	_____	_____
Professional Competence	_____	_____	_____
Patient Relationship	_____	_____	_____
Physician Relationship	_____	_____	_____
Availability for Patients	_____	_____	_____

How many years have you known the applicant? \_\_\_\_\_

Is the applicant's health adequate to perform the privileges associated with his/her specialty?

Yes  No

Does the applicant have any substance abuse, mental/emotional illness or disruptive behavior problems/history?

Yes  No

Is there any **additional confidential** information that you feel may be helpful to us in our consideration of this applicant?  Yes  No

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date