HEALTH CARE FACILITY INQUIRY
REGARDING HEALTH CARE PROFESSIONAL

SECTION I. INQUIRY
(To be completed by inquiring health care facility)

Date of Inquiry: _____

Inquiring Health Care Facility:

Facility Name: _____

Address: _____

Contact: _____ Phone: _____

Email Address: _____ Fax Number: _____

Receiving Health Care Facility:

Name: _____

Address: _____

Contact (if known): _____ Phone (if known): _____

Email Address (if known): _____ Fax Number: _____

Name of Health Care Professional: _____

Maiden Name/Other Name(s) Used: _____

Professional License or Certification Number: _____

Certification pursuant to N.J.A.C. 13:45E-6.1(a):

I certify that I am making this inquiry for the purpose of evaluating a health care professional for *(check all that apply)*:

☐ Hiring ☐ Continued employment ☐ Continued privileges

Name *(print)*: _____

Title *(print)*: _____

Signature: _____ Date: _____

SECTION II. RESPONSE
(To be completed by receiving health care facility)

Date Inquiry Received: _____ Date Response Sent: _____

Name of Health Care Professional *(if different from name provided above in Section I. Inquiry)*: _____

Title(s) of Position(s) Held: _____

Dates Employed: From: _____ To: _____

Did the health care professional receive a performance evaluation from the receiving facility?

☐ No: If "No," do not complete the rest of this form. Sign and date the form at Section II.

☐ Yes: If "Yes," complete the rest of this form.

Attach a copy of the health care professional's performance evaluation when returning this form to the inquiring facility **only if:**

(1) the evaluation has been signed by the evaluator and shared with the health care professional;

(2) the health care professional has had the opportunity to respond; and

(3) the health care professional's response, if any, is being taken into consideration in completing this inquiry form.

HEALTH CARE FACILITY INQUIRY REGARDING HEALTH CARE PROFESSIONAL (Continued)

If the health care professional is no longer employed or holds privileges at the receiving health care facility, state the reason for the separation of the health care professional from employment and/or the cessation of the health care professional's privileges at the receiving health care facility *(attach additional sheets if necessary)*:

Provide information about the health care professional's job performance as it relates to patient care *(see instructions)* *(attach additional sheets if necessary)*:

Is the health care professional eligible for re-employment by the receiving health care facility?

☐ Yes ☐ No

During the seven years preceding the date of this inquiry, have you submitted any report about this health care professional to *(check all that apply):*

☐ the Clearinghouse Coordinator within the division pursuant to N.J.S.A. 26:2H-12.2b;

☐ the Medical Practitioner Review Panel pursuant to N.J.S.A. 26:2H-12.2a; or

☐ any Board.

Attach copies of reports and any supporting documentation submitted to these entities when returning this form to the inquiring facility.

Is the report pending acceptance or rejection by the Clearinghouse Coordinator?

☐ Yes ☐ No

I certify that the foregoing statements made by me are truthful and made in good faith and without malice. I am aware that if any of the foregoing statements made by me are untruthful, made in bad faith, and/or with malice, I am subject to punishment and the receiving health care facility is subject to penalties pursuant to N.J.S.A. 26:2H-12.2c and N.J.A.C. 8:30-1.6.

Name *(print)*: _____

Title *(print)*: _____

Signature: _____ Date: _____