COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

400 – 175 Western Parkway,
Bedford, Nova Scotia
Canada B4B 1V0
Phone: (902) 422-5823
Fax: (902) 422-5035
www.cpsns.ns.ca

Annual Sponsorship Renewal Evaluation

Dear Dr. <SPONSOR>;

The following form is to be completed by yourself, in relation to the sponsorship of Dr. <NAME>, within the <NAME> Zone.

The purpose of this evaluation is to provide us with information related to this physician's practice and to also inform us of your intent to continue sponsorship for the year <###>.

Location:

Practice Setting (Indicate all that apply)

- ☐ Office
- ☐ Hospital
  - ☐ Out Patient
  - ☐ In-Patient
  - ☐ Emergency
  - ☐ Other (Specify_____)
- ☐ Community
  - ☐ Nursing Home
  - ☐ Other (Specify_____)

1. Clinical Performance

Do you have any information that would indicate a concern about the level of this physician's clinical performance?

Yes □ No □

If yes, please provide details

_____
_____
_____
_____

2. Communication/Interpersonal Skills

Do you have any information that would indicate a concern about this physician's communication/interpersonal skills with:

a)	patients and/or families	Yes □	No □
b)	other physicians	Yes □	No □
c)	other health care professionals	Yes □	No □
d)	office/hospital staff	Yes □	No □

If yes, please provide details

_____
_____
_____
_____

3. Public Health, Medico-Legal, Ethical

Do you have any information that would indicate a concern about how this physician deals with public health, medico-legal or ethical issues?

Yes □ No □

If yes, please provide details

_____
_____
_____
_____

4. Professionalism

Do you have any information that would indicate a concern about how this physician demonstrates:

(a) responsibility for continuing care of patients,	Yes □ No □
(b) transfer of care to another physician,	Yes □ No □
(c) appropriate use of laboratory and diagnostic imaging resources,	Yes □ No □
(d) appropriate participation in community and hospital activities,	Yes □ No □
(e) willingness to collaborate with other health professionals in the care of patients,	Yes □ No □
(f) appropriate documentation, including hospital records	Yes □ No □

If yes, please provide details

_____
_____
_____
_____
_____

5. Other

Do you have any other concerns about this physician that are not noted above?

Yes □ No □

If yes, please provide details *

_____
_____
_____
_____

6. Overall assessment

I am of the opinion that this physician is performing at the level of an established physician (i.e. a doctor settled in the community who has the confidence of patients, peers, and co-workers).

Yes □ No □

If no, please provide details *

_____
_____
_____
_____

Have areas of concern been discussed with the physician? Yes □ No □

7. For the year <####> I recommend:

- ☐ Continuation of sponsorship with sponsor-only oversight
- ☐ Continuation of sponsorship with supervision
- ☐ Discontinuation of sponsorship

Comments

_____
_____
_____
_____

_____ _____

Signature of Sponsor Date