



Banner Gateway
Medical Center

CLINICAL COMPETENCE PEER REFERENCE

IMPORTANT

Please provide the name of a peer reference within your same specialty that will verify your current clinical competence and recent experience within the past two (2) years for the privileges you have requested. The person you name must have acquired the requisite knowledge through recent observation of your professional performance and clinical competence and preferably have had organizational responsibility for oversight of your performance. If you have completed training within the last five years – list your Program Director. Reference may not be a relative. Further references may be required by the Medical Staff.

Peer Reference for: _____

Please Print Name

NAME: _____

TITLE: _____

ADDRESS: _____

PHONE: (_____) _____

FAX: (_____) _____

EMAIL: _____