VERIFICATION OF STAFF COMPETENCE

DATE: (REVIEW DATE)

TO: (COMPANY NAME)
(CONTRACT TYPE)
(ADDRESS)
(CITY) (ZIP CODE)
(CONTACT PERSON)
(PHONE NUMBER)
(FAX NUMBER)

FROM: (YOUR NAME AND PHONE NUMBER)

RE: **EVALUATION OF CONTRACT CLINICAL SERVICES**

We are conducting an evaluation of the clinical services that we provide to our patients through contractual arrangements with other organizations, and your organization is the current provider of the above referenced clinical service. We are conducting this evaluation in order to assure high quality patient care and to meet the requirements of the Joint Commission, Medicare, and the State hospital licensing authority and other accreditation and/or regulatory agencies.
One important element of the evaluation process concerns the clinical competence of the individuals who provide the service. Please respond to the questionnaire below to verify that the individuals employed by you, who provide services to our patients, pursuant to the contract that this memorandum references, are in fact clinically competent to provide such services. We will appreciate your reply at your earliest convenience. Please let us know if you require additional information.

Questionnaire

Please indicate the method(s) by which your organization assures that you have assessed and validated the clinical competence of individuals that you assign to provide care under the above referenced contract:

- [] 100% audit of clinical competence assessment records
- [] Audit by representative sampling of clinical competence assessment records
- [] Other method of audit_____

Audit conducted by_____ (name or department) Date of audit_____

The Vendor hereby represents and warrants that above stated facts are true and correct and that the undersigned is authorized to bind Vendor to the information contained herein. The Vendor certifies that the information contained herein is correct and accurate.

Questionnaire completed by_____ (Please print name and title)

Signature_____ Date_____

Attachment