**Health Sciences Clinical Professor Series, Without Salary (WOS) Affiliate Sites**

 **Referee Feedback Form**

**Confidentiality Statement**

Although the contents of your letter/form may be passed on to the candidate at prescribed stages of the review process, your identity will be held in confidence. The material made available will lack the letterhead/header, the signature block, and material below the latter (comments, if applicable). Therefore, material that would identify you, particularly your relationship to the candidate, should be placed below the signature block. In any legal proceeding or other situation in which the source of the confidential information is sought, the University does its utmost to protect the identity of such sources.

**DATE:** **Click or tap to enter a date.**

**FROM:** **Department Chair Name** **LETTER CODE**

**TO:** **Evaluator Name**

Please describe the following:

Professional Title and Institution: **List Evaluator Title and Institution+Dept Name**

Area(s) of Expertise/Qualifications: **List Evaluator Expertise**

Relationship to Candidate (past and present, including prior mentorship): **Describe Evaluator Relationship to Candidate**

**SUBJECT: Faculty/Candidate Name for**  **to** **, Without Salary**

The Department of Dept Name at the UC Irvine School of Medicine is proposing Faculty Name for the action proposed above. The Department and the School of Medicine require professional references: experts in the field who can give important feedback about the candidate.

Please complete the evaluation form of the candidate’s qualifications for the proposed action in the following categories:

**Professional/Clinical Competence/Performance**

|  |
| --- |
| Knowledge of basic/clinical sciences; Demonstrates commitment to the delivery of safe, cost-effective, patient-centered care **[ ]  Unsatisfactory [ ]  Satisfactory [ ]  Superior [ ]  Unable to assess** |

**Teaching/Mentorship (Quality of Teaching/Supervising/Mentoring activities)**

|  |
| --- |
| Demonstrates a strong interest in the education of healthcare professionals, fulfills teaching responsibilities**[ ]  Unsatisfactory [ ]  Satisfactory [ ]  Superior [ ]  Unable to assess** |

**Scholarly/Creative Activity**

|  |
| --- |
| Innovations, Publications, Presentations, Grants, Interdisciplinary Collaboration**[ ]  Unsatisfactory [ ]  Satisfactory [ ]  Superior [ ]  Unable to assess** |

**Service/Collaboration**

|  |
| --- |
| Participates in organized clinical discussions, interdisciplinary sessions, journal clubs and/or conferences**[ ]  Unsatisfactory [ ]  Satisfactory [ ]  Superior [ ]  Unable to assess** |

**Additional Information**

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The UC Irvine School of Medicine thanks you for participating in the review process. If you have any questions, please contact Dept Contact Name and Email/Number. Your name typed and date at the bottom of this page will suffice as a signature.

**Signature:**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidential Comments:**