



Oversight Peer Practice Assessment Form for Provisional Specialists

Name: _____ Licence #: _____
(of physician requiring oversight)

Discipline: _____

Practice location: _____

Assessment period: _____

Having completed a review of five (5) medical records, please record your general opinion of the information in the medical records.

Medical Record	Diagnosis	Standard of Care		
		Met	Met with Suggestions	Not Met
Medical Record #1				
Medical Record #2				
Medical Record #3				
Medical Record #4				
Medical Record #5				

Are there any concerns with team interactions?	Yes _____	No _____
If yes, please provide details:		

Are there any concerns with professional behaviours?	Yes _____	No _____
If yes, please provide details:		

COMMENTS

Supervising Physician (Please print)

Supervised Physician (Please print)

Supervising Physician (Signature)

Supervised Physician (Signature)

Date

Date

Copy of completed report sent to NLHS (please tick)