

North Dakota Board of Medicine  
PHYSICIAN ASSISTANT  
EMPLOYMENT REFERENCE FORM

**TO APPLICANT:** The North Dakota Board of Medicine requires letters from all facilities (hospitals, clinics, etc.), where you have practiced within the past **three** years. The Board reserves the right to request any additional letters during the licensing process. These forms must be completed by the hospital/clinic/facility and mailed **directly** to the Board at **4204 Boulder Ridge Rd, Ste 260; Bismarck, ND 58503-6162**. The completed form may also be faxed to 701-989-6392 but **MUST** be sent with a fax cover sheet that provides the Board with the required primary source verification. The form may also be emailed to [briplinger@ndbom.org](mailto:briplinger@ndbom.org). In addition, the forms must meet the following criteria:

- a) Currently dated
- b) Contain an original signature
- c) Be completed in full

**Name of Applicant:** \_\_\_\_\_  
(First Name) (MI) (Last Name)

**If the hospital/clinic or other facility requires a release (attached) to complete this information on your behalf, complete the Affidavit and submit it to the facility with this form.**

---

**Important:** The processing time for licensure directly depends on timely receipt of critical forms such as this.

From (name of hospital/facility): \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Area Code/Phone Number Email Address

---

**Dates of employment/privileges:** \_\_\_\_\_ **to** \_\_\_\_\_  
month/year month/year

In what capacity are you acquainted with the applicant? \_\_\_\_\_

\_\_\_\_\_

**NOTE: If you answer "YES" to any of the following questions please give an explanation (circle answers).**

1. Have you ever received reports of poor medical practice by this physician assistant, or have you discussed concerns you had about his/her practice with medical staff officers at a hospital? Yes  No
2. Are you aware of any boundary or ethical issues that would affect this applicant's ability to practice as a physician assistant? Yes  No
3. Do you know of any derogatory information about this applicant with respect to his/her ability to practice as a physician assistant? Yes  No
4. Do you know of any lawsuits having to do with this applicant's practice that this physician assistant has either lost or settled out of court? Yes  No
5. Do you know of any restrictions, limitations, or other actions of any nature taken against this physician assistant by a hospital or other health-related entity? Yes  No
6. Do you know of any issue(s) that would affect this applicant's ability to work as a physician assistant in a competent, ethical, or professional manner? Yes  No

**NOTE: If you answer "NO" to questions 7 or 8, please provide an explanation.**

7. Does this physician assistant accept medical staff and hospital policies and function willingly according to these policies? Yes  No
8. Do you recommend this physician assistant for a license in North Dakota? Yes  No

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Printed Name of Reference**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Email Address**