North Dakota Board of Medicine
HOSPITAL/CLINIC 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. This form 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. In addition, the forms must meet the following criteria:

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

Please be sure to indicate the applicant's name below for identification purposes.

Name of Applicant: _____
(First Name) (Middle Name or MI) Last name)

If the hospital/clinic or other facility requires a release to complete this information on your behalf, please go to Item #7 of the online application instructions and print/complete the Affidavit and submit it to the facility with this form.

REFERENCE SOURCE: Please complete this form, sign, and return to the ND Board of Medicine in a sealed envelope. **Please print or type all information.**

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

Dates of employment/privileges: _____ to _____
month/year month/year

1. In what capacity are you acquainted with him/her? _____

_____

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

2.	Have you ever received reports of poor medical practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	Yes	No
3.	Are you aware of any boundary or ethical issues that would affect this applicant's ability to practice medicine?	Yes	No
4.	Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?	Yes	No
5.	Do you know if this physician has or has this physician had in the past, any mental or physical illnesses or other issues that interfere with his/her medical practice?	Yes	No

6.	Do you know if this physician has ever abused alcohol or drugs or shown signs of chemical dependency?	Yes	No
7.	Do you know of any lawsuits having to do with this physician's medical practice that this physician has either lost or settled out of court?	Yes	No
8.	Do you know of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	Yes	No

NOTE: If you answer "NO" to questions 9, 10, or 11, please give an explanation.

9.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	Yes	No
10.	Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices?	Yes	No
11.	Do you recommend this physician for a medical license in North Dakota?	Yes	No

COMMENTS: _____

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_____

_____

_____

_____ _____

Signature **Date**

_____

Title

_____

Email Address