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 bripplinger@ndbom.org. 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) (MI – if known) (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 him/her? _____

_____

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 9, 10, or 11, please provide an explanation.

9. Does this physician assistant accept medical staff and hospital policies and function willingly according to these policies? Yes ☐ No ☐

10. Does this applicant enjoy professional respect among his or her colleagues and in the community where this physician assistant practices? Yes ☐ No ☐

11. Do you recommend this physician assistant for a license in North Dakota? Yes ☐ No ☐

COMMENTS: _____

_____

_____

_____

_____ _____

Signature **Title**

_____ _____

Name of Personal Reference (Please Print) **Date**

_____

Email Address