North Dakota Board of Medicine
HOSPITAL/CLINIC/EMPLOYMENT REFERENCE FORM

TO APPLICANT: The North Dakota Board of Medicine requires letters from all facilities (hospitals, clinics, employers, 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/employer and mailed **directly** to the Board by: mail at **4204 Boulder Ridge Rd, Ste 260, Bismarck, ND 58503-6162**, email to license@ndbom.org, or faxed to **701-989-6392** but MUST be sent with a fax cover sheet that provides the Board with the required primary source verification.

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

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

If the hospital/clinic/employer 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.

If you are submitting this form to a hospital to verify your privileges, please direct it to the Medical Staff Services office at the hospital.

From: (name of hospital/clinic/employer)____

____
Address City State Zip

____
Area Code Phone Number

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

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

1.	Have there ever been reports of poor medical practice of this physician or have concerns been raised at this facility about the physician's ability to practice medicine or function in accordance with facility policies?	Yes	No
2.	Have any actions been taken by this facility against the physician's privileges, credentials, or employment?	Yes	No
3.	Are you aware of any boundary or ethical issues that would affect this physician'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 have any knowledge of any issue(s) that would affect this physician's ability to practice medicine?	Yes	No
6.	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

7. Do you know of any restrictions, limitations or other actions of any nature taken against this physician by any other medical facility or other health related entity? Yes No

COMMENTS: ____

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Signature

____
Date

____
Print Name

____
Email Address

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Title and Position with Facility