

**North Dakota Board of Medicine
PHYSICIAN ASSISTANT
SUPERVISING PHYSICIAN REFERENCE FORM**

TO APPLICANT: The North Dakota Board of Medicine requests completion of the supervising physician form from your supervising physician(s) during the past three (3) years of employment. These forms must be mailed from the supervising physician(s) **directly** to the **ND Board of Medicine at 4204 Boulder Ridge Rd, Ste 260; Bismarck, ND 58503-6162**. The 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. 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 _____

How long have you know the applicant? _____

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 been aware of inadequate or poor medical practice by this physician assistant or have you discussed concerns you had about his/her practice with other members of the medical staff? 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. Are you aware of any derogatory information about this physician assistant with respect to his/her ability to practice? Yes No

NOTE: If you answer "NO" to questions 4, 5 or 6, please provide an explanation.

4. Does this physician assistant exhibit a high degree of ethical and moral standards in his/her practice of medicine? Yes No

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

6. 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