North Dakota Board of Medicine
PHYSICIAN REFERENCE FORM

TO APPLICANT: The North Dakota Board of Medicine requests completion of **TWO** personal reference forms. This form must be signed and sent from the reference **directly** to the Board by: mail to the **ND Board of Medicine at 4204 Boulder Ridge Rd, Ste 260; Bismarck, ND 58503-6162**, emailed 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. The reference forms must meet the following criteria:

a) Currently dated
b) Contain an original signature
c) **Two (2)** forms sent by physicians familiar with your practice and who have known you for one year or more. **Family members or physicians who are in the practice you are joining will NOT be accepted**.

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

Name of Applicant: ____
(First Name) (MI – if known) (Last Name)

From: ____

____
Address City State Zip

______________________ ______________________
Area Code/Phone Number Email Address

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1. How long have you known the applicant? ______________________________

2. 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).

3. Are you aware of substandard medical practice by this physician or do you have concerns about the physician's ability to practice medicine? Yes No

4. Are you aware of any boundary or ethical issues that would affect this applicant's ability to safely practice medicine? Yes No

5. Are you aware of any derogatory information about this physician with respect to his/her ability to safely practice medicine? Yes No

6. Do you have any knowledge of any issue(s) that would affect this applicant's ability to safely practice medicine? Yes No

NOTE: If you answer “NO” to questions 7 or 8 please provide an explanation.

7.	Does this physician exhibit a high degree of ethical and moral standards in his/her practice of medicine?	Yes	No
8.	Do you recommend this physician for a medical license in North Dakota?	Yes	No

COMMENTS: ____

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______________________________ ______________________________

Signature **Title**

______________________________ ______________________________

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

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Email Address