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. The form may also be emailed to license@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) (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.**

From (name of hospital/facility): _____

_____
Address City State Zip

_____ _____
Area Code/Phone Number Facility Email Address

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

1. In what capacity are you acquainted with the physician? _____

NOTE: If you answer "YES" to any of the following questions please give an explanation

2. Have there ever been reports of poor medical practice by this physician or have concerns been raised at this facility about the physician's ability to practice medicine? ☐ 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 a hospital or other health related entity? ☐ Yes ☐ No

NOTE: If you answer "NO" to questions 8 or 9, please give an explanation.

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

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

COMMENTS: _____

_____

_____

_____ _____

Signature Date

_____ _____

Print Name Email Address

_____

Title