North Dakota Board of Medicine
PHYSICIAN REFERENCE FORM

TO APPLICANT: The North Dakota Board of Medicine requests completion of **TWO** personal reference forms. These forms must be mailed from the reference sources **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 license@ndbom.org In addition, the reference forms must meet the following criteria:

1. Currently dated
2. Contain an original signature
3. **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**.

Name of Applicant: _____
(First Name) (MI) (Last Name)

REFERENCE: Please complete this form, sign, and return to the ND Board of Medicine in a sealed envelope or send from your personal email.

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

From: _____

_____
Address City State Zip

_____ _____
Area Code/Phone Number Email Address

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.

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

6. Do you have any knowledge of any issue(s) that would affect this applicant's ability to 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:

_____

_____

_____

_____

_____ _____

Signature of Personal Reference Title

_____ _____

Printed Name of Personal Reference Date

_____

Email Address