

**Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
 Wakefield, MA 01880 Telephone: (781) 876-8210 Fax: (781) 876-8383
 Website: massmedboard.org**

EVALUATION FORM

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant: _____ Date: ____/____/____

Please PRINT your name _____

Name of facility: _____ State _____

INSTRUCTIONS TO THE CHIEF OF SERVICE OR PROGRAM DIRECTOR WHO MUST BE A PHYSICIAN: Please complete the questions below and forward this form to the applicant.

1. How long have you known the applicant? From: ____/____/____ To: ____/____/____

A. In what capacity colleague affiliated in practice other: _____

B. Date(s) of applicant's affiliation at facility: From: ____/____/____ To: ____/____/____

C. Applicant's Status: Intern Resident Fellow Staff Member Other _____

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?
 No *Yes (if "yes" please explain below)

3. Please rate the following (if "BELOW AVERAGE or "POOR" , explain in detail on the back of this evaluation and/or attach a separate sheet)

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

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4. Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below. NO YES

5. **PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.**

6. The above comments are based on the following:

- Close personal observation
- General impression
- A composite of previous evaluations by other physicians
- Other _____

7. **RECOMMENDATIONS:**

- I recommend _____ for licensure in Massachusetts.
- I recommend _____ for licensure in Massachusetts, with the following reservations

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- I do not recommend _____ for licensure in Massachusetts

I certify that at the time of completion of the above physician's training, and/or during my association with the physician, he/she was competent to practice medicine.

Signature: _____ (check one) M.D. or D.O.

Print Your Name: _____ Date: ____/____/____

Academic title or position: _____ Phone number: _____

Specialty/Service or Department: _____

Please return this completed form to the applicant in a sealed envelope, signed or stamped across the seal. Thank you.