



## Department of Health Professions Commonwealth of Virginia

**Board of Medicine**  
9960 Mayland Drive, Suite 300  
Henrico, Virginia 23233-1463

**Email – Medbd@dhp.Virginia.gov**  
**(804) 367-4600**  
**FAX 804-527-4426**

Please print or type name, address, city and state, of employment setting.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please print or type name of Applicant

The Virginia Board of Medicine, in its consideration of a candidate for licensure, depends on information from persons and institutions regarding the candidate's employment, training, affiliations and staff privileges. Please complete this form to the best of your ability and return it to the Board. The information you provide will be given consideration in the processing of this candidate's application. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the board in connection with the processing of my application.

Signature of Applicant \_\_\_\_\_

1. Date and type of service: This individual served with us as \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_.  
(Month/Year) (Month/Year)

2. Please evaluate: (Please indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark)

- Recommend highly and without reservation ☐; Recommend as qualified and competent ☐
- Recommend with some reservation (explain) \_\_\_\_\_
- Do not recommend (explain) \_\_\_\_\_

4. Of particular value to the Board in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). The Board appreciates such comments from you.

\_\_\_\_\_  
\_\_\_\_\_

5. The above report is based on: (please indicate with check mark)

- Close personal observation ☐; General impression ☐; A composite of evaluations ☐;
- Other: \_\_\_\_\_

Date: \_\_\_\_\_

Signed by: \_\_\_\_\_

Print or type name: \_\_\_\_\_

Title: \_\_\_\_\_

*(This report will become a part of the applicant's file and may be reviewed by the applicant upon request.)*