

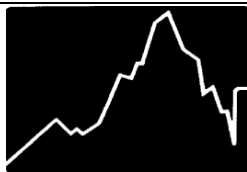
PLEASE CHECK APPROPRIATE PROFESSION

☐ Acupuncturist
☐ Genetic Counselor
☐ Physician Assistant
☐ Radiologist Assistant

☐ Athletic Trainer
☐ Midwife
☐ Polysomnographer
☐ Respiratory Therapist

☐ BCaBA
☐ Occupational Therapist
☐ Radiologic Technologist

☐ BCBA
☐ Occupational Therapist Assistant
☐ Radiologic Technologist - LIMITED



Virginia Department of Health Professions

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

Phone: (804) 367-4600
 Fax: (804) 527-4426
 Email: medbd@dhp.virginia.gov

Please provide name and address of organization/individual exactly as it appears on your application chronology

Clearly print/type name of applicant _____

Last 4 of Social Security Number: _____

The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. 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: (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 us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate 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 (Required): _____

Signed by: _____

Signator Contact Number: (_____) _____

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.)