

Temp. Permit No.

FORM B RESPIRATORY CARE REFERENCE FORM

In order for the Georgia Composite Medical Board to adequately evaluate the applicant named below for certification to practice as a Respiratory Care Practitioner in the State of Georgia, please complete all pertinent sections in detail. This reference form must be completed and signed by a **licensed physician** with whom the **applicant practices with at the time of application, or who is in charge of the Respiratory Program**. This form must be mailed **directly from the physician** to the Georgia Composite Medical Board at the following address:

**Georgia Composite Medical Board
Respiratory Care Professional Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303**

Section 1: - To Be Completed by Applicant:

Name: Last: _____ First: _____ M.I.: _____ Maiden: _____

Mailing Address: _____

Telephone Number: _____

Place of Employment or College Clinical: _____

City & State of location indicated above: _____

Section 2: To be completed by Physician or Program Director; however, the Medical Director must sign the form:

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	<input type="checkbox"/>				
Quality of Work	<input type="checkbox"/>				
Professional Responsibility	<input type="checkbox"/>				

Reference Form Continued On Next Page

FORM B - RESPIRATORY CARE REFERENCE FORM (continued)

Date Employment Started: month/_____ day/_____ year/_____

In your professional opinion is the applicant capable of performing competently as a Respiratory Care Professional? Yes No

Would you recommend certification based on applicant's abilities? Yes No
If no, please explain.

I hereby certify that the above applicant is or has been employed under my supervision as a health professional in Respiratory Care *from* (mm/yy)____/____ *to* (mm/yy) ____/____

Applicant worked full time part time, approximately ____ hours per week.

Would you rehire (if applicable) Yes No? If no, please explain.

Additional Comments:

If you are completing this reference form, please list the name of the business, hospital, or school where you are currently practicing.

Name of Business, Hospital or School: _____

City & State of above location: _____

Physician's Name: *(please type or print)* _____

Physician's Signature: _____

License Number: _____ **State of Licensure:** _____

Business Telephone Number: _____ **Date:** _____