FORM C
PHYSICIAN ANESTHESIOLOGIST ASSISTANT
REFERENCE FORM

**MUST HAVE OBSERVED THE CANDIDATE IN HIS/HER CAPACITY AS AN AA STUDENT OR PRACTICING AA

FROM (PHYSICIAN'S NAME): _____**MD/DO (CIRCLE ONE)**

PHYSICIAN'S SPECIALTY:_____**BOARD CERTIFIED:** _____**YES** _____**NO**

FOR CANDIDATE: _____
Last Name **First Name** **Middle Name**

I offer the following evaluation:

	Above Average	**Average**	**Below Average**
Demonstrates Competence in Providing Anesthesia Care			
Assessment of Clinical Skills			
Professionalism			
Quality of Patient Care			
Seeks Consultation when necessary			
Demonstrates Openness to Criticism			
Emotional Stability			

2. What is your professional relationship? (preceptor, clinical director, supervising MD, etc) Must have observed the candidate in his/her capacity as an AA student or practicing AA.

_____

3. Length of time you observed/ worked with candidate? **(Provide month/year range)** _____

_____

4. I **do have** / **do NOT have (CIRCLE ONE)** any reservations in recommending the above PA for licensure. If you have reservations, please explain._____

_____

5. Do you have reservations or concerns about this applicant that you would like to discuss in a phone call with Medical Board staff? _____**YES** _____**NO (CIRCLE ONE)**.

If yes, what is the best day and time to contact you?_____

_____
PHYSICIAN SIGNATURE Date

_____
Address

_____
City State Zip

_____
Phone # Fax #

Email to: gcmb.paandaa@dch.ga.gov (Preferred Method)
Or Mail to:
Georgia Composite Medical Board
Attention: Physician Assistant Unit
2 MLK Jr. Drive, S.E. East Tower, 11th Floor
Atlanta, GA 30334