

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	Below Average	Average
Demonstrates Competence in Primary Care Practice			
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? Dates if available _____

4. I do have ____ do not have ____ 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** (please circle one).

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

Physician Signature Date

Address

City State Zip

Phone # Fax #

Mail to:
Georgia Composite Medical Board
Attention: Physician Assistant Unit
2 MLK Jr. Drive, S.E. East Towers, 11th Floor
Atlanta, GA 30334