FORM D

PHYSICIAN ASSISTANT
REFERENCE FORM

****MUST HAVE OBSERVED THE CANDIDATE IN HIS/HER CAPACITY AS A PA STUDENT OR PRACTICING PA**

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 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 a PA student or practicing PA.

_____

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 (please 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