

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**

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 (check 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 (check one).** If yes, what is the best day and time to contact you? _____

PHYSICIAN SIGNATURE _____ **Date** _____

Address

City **State** **Zip**

Phone # **Fax#**

Email to: gcomb.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