Temp. Permit No.

FORM B1
RESPIRATORY CARE REFERENCE FORM
REINSTATEMENT

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**. **If a Medical Director Reference Form cannot be submitted, a Prospective Employer's Reference Form (Form B11) may be submitted instead.** 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	☐	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐	☐
Professional Responsibility	☐	☐	☐	☐	☐

Reference Form Continued On Next Page

FORM B1 - 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:

_____

_____

Name of Business 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:** _____