

Temp. Permit No.

FORM B RESPIRATORY CARE REFERENCE FORM

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 in another state as a Respiratory Therapist or previously practiced, or the Medical Director (licensed physician) who is in charge of the Respiratory Program of the school you are currently or recently a graduate. If the current Medical Director cannot complete the Reference Form, a Prospective Employer's Reference Form (Form B11) may be submitted instead. **An original signature is required for the Medical Director/Licensed physician.**

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., 6th 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 if you are a student: _____

City & State of location indicated above: _____

Section 2: To be completed by your current or previous Medical Director or the Medical Director of the Respiratory Care Program of the school you are currently or recently attended.

Please evaluate the applicant in the following areas:

	Excellent	Good	Average	Poor	Not able to make judgment
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reference Form Continued On Next Page

FORM B - RESPIRATORY CARE REFERENCE FORM (continued)

(If the applicant is a student, you can omit this section)

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.

(If the applicant is a student, you can omit this section)

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? Yes No If no, please explain.

Additional Comments:

If you are completing this reference form, please list the name of the business, hospital, or school where you are currently practicing.

Name of Business, Hospital or School: _____

City & State of above location: _____

Physician's Name: *(please type or print)* _____

Physician's Signature: _____
(Original signature required)

License Number: _____ **State of Licensure:** _____

Business Telephone Number: _____ **Date:** _____