

FORM D
PHYSICIAN ASSISTANT PRIMARY CARE
REFERENCE FORM

FROM (PHYSICIAN'S NAME): _____ **MD/DO (CIRCLE ONE)**

PHYSICIAN'S SPECIALTY: _____ **BOARD CERTIFIED: YES NO**

FOR CANDIDATE:

Last Name	First Name	Middle Name
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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?** _____
3. **Length of time known/ worked with candidate?** _____
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 _____

Mail to:
Georgia Composite Medical Board
Attention: Physician Assistant Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303

Address _____
City _____ State _____ Zip _____

Phone # _____ Fax # _____