

# NORTH CAROLINA MEDICAL BOARD

## PHYSICIAN REFERENCE FORM

**TO APPLICANT:** The North Carolina Medical Board requires completion of two reference forms. These forms must be sent from the reference sources **directly** to the NC Medical Board by emailing the form to [license@ncmedboard.org](mailto:license@ncmedboard.org).

In addition, the forms must meet the following criteria:

- a. Original or verified electronic signatures (DocuSign, VeriDoc, etc.) are acceptable. Adobe signatures and typed names are not accepted.
- b. They should be completed by physicians who have observed your work in a clinical environment within the past three years and who are knowledgeable about your competence in your intended area of practice.
- c. Reference forms cannot be from a relative.

**Name of Applicant:** \_\_\_\_\_

**\*\* On the application form, the applicant has agreed to release, discharge and exonerate any person furnishing information from any and all liability of every nature and kind arising out of this furnishing or inspection of such documents, records, other information or the investigation made by the North Carolina Board. \*\***

**REFERENCE SOURCE:** Please complete this form and return to the NC Medical Board. Your response is confidential, pursuant to North Carolina law. **Please print or type all information.**

**Important:** The processing time for licensure directly depends on timely receipt of critical forms such as this.

Reference Name	MD/DO
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Address	City	State	Zip
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Phone Number	Email Address
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1. How long have you known the applicant? \_\_\_\_\_

2. In what capacity are you acquainted with him/her? \_\_\_\_\_

\_\_\_\_\_

**If you answer “YES” to questions 3 - 9, you will need to provide an explanation.**

- |   |     |    |     |
|---|-----|----|-----|
| 3. Have you ever received reports of poor medical practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital? | Yes | No | N/A |
| 4. Have you ever received reports of poor relationships between this physician and other health care workers?   | Yes | No | N/A |
| 5. Do you know of any derogatory information about this physician with respect to his/her ability to practice medicine?   | Yes | No | N/A |
| 6. Do you know if this physician has had and mental, emotional or physical illnesses that have interfered with his/her medical practice within the past five (5) years?               | Yes | No | N/A |
| 7. Do you know if this physician has abused alcohol or drugs or shown signs of chemical dependency within the past five (5) years?  | Yes | No | N/A |
| 8. Do you know of any judgements, awards, payments or settlements regarding this physician?   | Yes | No | N/A |
| 9. Do you know of any restrictions, limitations or other disciplinary actions of any nature taken against this physician by a hospital or other health care organization?             | Yes | No | N/A |

**If you answer “NO” to questions 10 - 13, you will need to provide an explanation.**

- |   |     |    |     |
|---|-----|----|-----|
| 10. Does this physician understand medical staff and hospital policies and abide by these policies?                                 | Yes | No | N/A |
| 11. Does this physician enjoy professional respect among his or her colleagues and in the community where this physician practices? | Yes | No | N/A |
| 12. Do you recommend this physician for unrestricted medical licensure in North Carolina?   | Yes | No | N/A |
| 13. Have you observed this physician work in a clinical environment within the past three years?                                    | Yes | No | N/A |

**\*\* Additional comments are encouraged and assist the Board in evaluating the applicant. \*\***

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name of Institution**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**