NORTH CAROLINA MEDICAL BOARD
PHYSICIAN REFERENCE FORM

TO APPLICANT: The North Carolina Medical Board requests 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.**

In addition, the forms must meet the following criteria:

a. They must have an original signature. Signature stamps will not be accepted.
b. They should be completed by physicians who have interacted with you 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.

Please be sure to indicate your name below for identification purposes.

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.

Name _____ MD/DO _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

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 interacted with this physician within the past three years and are you knowledgeable about their competence in their intended area of practice?	Yes	No	N/A

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

COMMENTS: _____

_____

_____

_____ _____

Signature **Title**

_____ _____

Name of Hospital (if applicable) **Date**