

**Board of Registration in Medicine**  
**200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880**  
**Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org**

<b>EVALUATION FORM</b>
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I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please PRINT your name \_\_\_\_\_

Name of facility: \_\_\_\_\_ State \_\_\_\_\_

**INSTRUCTIONS TO THE CHIEF OF SERVICE OR PROGRAM DIRECTOR WHO MUST BE A PHYSICIAN: Please complete the questions below and return to the applicant with your name affixed across the envelope seal.**

1. How long have you known the applicant? From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

A. In what capacity?  supervisory  colleague  affiliated in practice  other: \_\_\_\_\_

B. Date(s) of applicant's affiliation at facility: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

C. Applicant's Status:  Intern  Resident  Fellow  Staff Member  Other \_\_\_\_\_

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?  No  Yes (if "yes" please explain below)

\_\_\_\_\_

\_\_\_\_\_

3. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on the back of this evaluation and/or attach a separate sheet)

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

(Continued on page 2)

4. Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.  NO  YES

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5. PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.

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6. The above comments are based on the following:

- Close personal observation
- General impression
- A composite of previous evaluations by other physicians
- Other \_\_\_\_\_

7. **RECOMMENDATIONS:**

I recommend \_\_\_\_\_ for licensure in Massachusetts.

I recommend \_\_\_\_\_ for licensure in Massachusetts, with the following reservations

\_\_\_\_\_  
 I do not recommend \_\_\_\_\_ for licensure in Massachusetts

Signature: \_\_\_\_\_ (check one)  M.D. or  D.O.

Print Your Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Academic title or position: \_\_\_\_\_ Phone number: \_\_\_\_\_

Specialty/Service or Department: \_\_\_\_\_

**PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.**