PHYSICIAN RECOMMENDATION FORM

This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant’s character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 7 of the application. The applicant’s signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name________________________________________________________________________
Signature___________________________________________________ Date__________________

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician)________________________________________

1. How long have you known the applicant?______________________________________________

2. What has been the nature of your relationship with the applicant?__________________________
_____________________________________________________________________________

3. How would you characterize the moral and professional conduct of the applicant?_____________
_____________________________________________________________________________

4. Would you recommend that the applicant be approved for licensure for the independent,
unrestricted practice of medicine?__________________________________________________

5. Circle the word(s) which best describes this applicant.

A. Marginal* Fully Meets Standards A. Clinical skills
B. Yes* No B. Any indication of chemical dependency?
C. Yes* No C. Any indication of malprescribing?

Completed By:
Print Name__________________________________________________ Phone_______________
Address_________________________________________________________________________
Signature__________________________________________________ Date__________________

*Please attach letter of explanation. 01/02