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

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

_____
Address

_____
City State Zip

_____
Phone # Fax #

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