SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:
- This form must be completed by a supervising physician who can evaluate your clinical performance.
- At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.
- Evaluation forms must be current within 120 days prior to Board review.
- The Evaluator must have no financial interest in your licensure in the State of Massachusetts.

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 Evaluating Hospital/Workplace: __________________________ State: ___

SUPERVISING PHYSICIAN INSTRUCTIONS:
- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. Date(s) of applicant’s affiliation at facility (month/year)? From: ____/____ To: ____/____

2. In what capacity did you supervise the applicant?  □ Department Chair  □ Chief of Service  □ Medical Director  □ Training Director  □ Supervising Physician  □ Chief Medical Office

3. Applicant’s Status:  □ Intern  □ Resident  □ Fellow  □ Staff Member  □ Other ___________

4. Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts? □ YES  □ NO

5. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).

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<th>Superior</th>
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(Continued on page 2)
6. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? □ YES □ NO (if "yes" please explain below)

________________________________________________________________________

7. 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. □ YES □ NO

________________________________________________________________________

8. Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.

________________________________________________________________________

9. The above comments are based on the following:

☐ Personal observation  ☐ General impression  ☐ A composite of evaluations by other physicians

☐ Other ________________________________________________

10. Recommendations:

☐ Recommend for licensure in Massachusetts.

☐ Recommend for licensure in Massachusetts, with the following reservations:

________________________________________________________________________

☐ Do not recommend for the following reason(s):

________________________________________________________________________

Signature of Evaluator: ____________________________________________ (check one) ☐ M.D.  or  ☐ D.O.

Name of Evaluator (Printed):_________________________________________ Date: _____/_____/_______

Title/Position: __________________________________________________________

E-mail address:_________________________________________________________ Phone number: ________________________

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

BOARD OF REGISTRATION IN MEDICINE

POLICY ON SUPERVISOR EVALUATIONS

POLICY 2017- 03

Adopted September 28, 2017

The Board and its Licensing Committee (Board) undertakes a rigorous and comprehensive process when evaluating the professional qualifications of an Applicant for a limited or initial license in Massachusetts. The honest and impartial assessment of an Applicant by his or her Program Director or Residency Director is a crucial component in the Board’s evaluative process.

All persons who submit Evaluations to the Board shall avoid any actual or perceived conflict of interest so as to ensure that the conflict does not affect patient safety, quality of care or the integrity of the services provided by the Board. A “conflict of interest” is a situation where financial, professional or personal interests (including the interests of immediate family members), may compromise one’s professional judgment or official responsibilities. A conflict of interest exists when an Evaluator may gain financially or professionally from an Applicant’s prospective employment.

All persons who submit an evaluation to the Board shall certify that they have knowledge of the Applicant’s performance and have reviewed the Applicant’s training record; that there is no evidence of any unprofessional behavior or any serious question of clinical competence; that the applicant has demonstrated competency to practice medicine without direct supervision; and that the Evaluator is the supervisor and has no conflict of interest, personally, professionally or financially, in recommending the Applicant for licensure.