



**District of Columbia Board of Medicine**  
**MEDICAL TRAINING LICENSE**  
**Character Reference Form**

The District of Columbia Board of Medicine, in its consideration of a candidate for licensure, depends on information by persons listed (references) regarding the candidate's character, employment and observed performance while providing care to patients and working with peers and staff. Please complete this form to the best of your ability and return it to the Board so the information you provide can be given consideration in the processing of this candidate's application.

**Applicant Name:** \_\_\_\_\_

I hereby authorize the release of any information to the D.C. Board of Medicine requested by the Board in connection with the processing of my application.

**Signature of Applicant**

\_\_\_\_\_  
 Name of Institution

\_\_\_\_\_  
 Address of Institution

1. Date and type of service: This individual served with us as \_\_\_\_\_  
 from \_\_\_\_\_ to \_\_\_\_\_. If you are responding for a training program, please provide the number of months of  
 (Month/Year) (Month/Year) professional or postgraduate training awarded \_\_\_\_\_.

2. Please evaluate: (Indicate with check mark)

		Poor	Fair	Good	Superior
Professional knowledge					
Clinical judgment					
Relationship with patients					
Ethical/professional conduct					
Interest in work					
Ability to communicate					

3. To your knowledge, has the applicant been the subject of any disciplinary or legal proceeding convened by a medical school, state regulatory agency or board, employer hospital or health care facility? Yes ☐; (if yes, please explain on a separate sheet) No ☐

4. Recommendation: (please indicate with check mark)

- Recommend highly and without reservation ☐; Recommend as qualified and competent ☐
- Recommend with some reservation (explain) \_\_\_\_\_
- Do not recommend (explain) \_\_\_\_\_

5. Of particular value to us in evaluating any candidate regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you.

6. The above report is based on: (please indicate with check mark)

- Close personal observation ☐; General impression ☐; A composite of evaluations ☐;
- Other: \_\_\_\_\_

7. Relationship to applicant

- Medical School Professor ☐; Program Director ☐; Attending Physician ☐; Other: \_\_\_\_\_

Date (Required): \_\_\_\_\_

Signed by: \_\_\_\_\_

Print or type name: \_\_\_\_\_

Title: \_\_\_\_\_