



**DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION
BOARDS OF MEDICINE AND PHYSICIAN ASSISTANT**

CHARACTER REFERENCE FORM

APPLICANT'S NAME

APPLICANT'S ADDRESS

Dear Sir/Madam

The applicant whose name and address appear above has applied for a license to practice as a Physician Assistant in the District of Columbia and lists you as a reference for his/her moral character and professional experience.

Please complete and return this form to the address below. Your prompt attention to this request will greatly assist the Board of Physician Assistant when considering the applicant for licensure. The Board will consider your reply as confidential information.

**Department of Health
Health Professional Licensing Administration
Board of Physician Assistant
899 North Capitol St., NE, 2nd Floor
Washington, DC 20002**

TO: District of Columbia, Board of Physician Assistant.

I hereby certify that since (date)_____, I have been closely associated with _____, residing in _____ as to be able to intelligently express an opinion as to his/her character, mental condition and habits, and tat to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits that are liable to interfere with the proper practice as a Physician Assistant.

REMARKS:

Name (Please Print or Type)

Signature/Title

Address