

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Board of Podiatry



PROFESSIONAL REFERENCE FORM

The District of Columbia Board of Podiatry evaluates the qualifications of applicants for licensure to practice as podiatrist in the District of Columbia.

The applicant named below has applied for a license to practice as a podiatrist and has listed you as a reference to his/her character. Your assistance with this evaluation will assist the Board when considering this applicant for licensure and is greatly appreciated. Please return this form directly to the Department of Health at the address provided at the bottom of the second page.

Applicant Name: _____

Applicant's Address: _____

I HEREBY CERTIFY THE FOLLOWING:

Professional relationship with applicant: _____

Approximate length of time known applicant: _____ Years _____ Months

Are you aware of any personal traits, habits, or conduct which would make the applicant unsuitable to be licensed as a podiatrist: _____ Yes _____ No

If yes, please explain _____

To your knowledge, is the applicant free from mental defects and/or drug habits: _____ Yes _____ No

If no, please explain _____

1. Please evaluate Applicant's performance by indicating with a check*:

	N/A**	POOR	FAIR	GOOD	SUPERIOR
Professional knowledge	<input type="checkbox"/>				
Clinical Judgment	<input type="checkbox"/>				
Relationship with patients	<input type="checkbox"/>				
Ethical/professional conduct	<input type="checkbox"/>				
Dependability	<input type="checkbox"/>				
Ability to communicate	<input type="checkbox"/>				

*For any attribute checked Fair or Poor, please elaborate in part 4.

**Unable to evaluate

2. Recommendation for licensure (Please indicate with check):

- 1. Recommend highly without reservation
- 2. Recommend as qualified and competent
- 3. Recommend with some reservation (explain below)
- 4. Do not recommend (explain below)

3. This evaluation is based on (Please indicate with check):

- 1. Close personal observation
- 2. General impression
- 3. A composite of evaluations
- 4. Other (Please specify below)

4. Relationship to applicant (Please indicate with check):

- 1. Program Director
- 2. Immediate Supervisor
- 3. Other (Please specify below)

4. Please give any additional information, which you feel would aid the Board in determining the qualifications of the applicant (Please use a separate sheet if necessary):

Name (Please Print or Type name of Evaluator)

PLEASE RETURN THIS FORM TO:

Signature of Evaluator

D.C. Board of Podiatry
P.O. BOX 37802
WASHINGTON, DC 20013

Title of Evaluator

Date