Commonwealth of Massachusetts Board of Registration in Medicine
178 Albion Street, Suite 330 – Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS: Complete this section and print your name on the top of the second page.

- This form must be completed by a supervising physician who can evaluate your clinical performance.
- If currently in training it must be completed by a Program Director.
- Evaluations must cover at least one year of current clinical activities. If you have been practicing at a facility for less than one year, you must request additional Evaluation Forms from previous supervisors to cover a full year.
- Locum tenens physicians must have evaluations from the most recent two years of assignments.
- The Evaluator must have no financial interest in your licensure in 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: _____ _____ _____

Applicant PRINT name:_____

Name of Evaluating Hospital/Workplace:_____ State: _____

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete both pages 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 ☐ Training Director ☐ Supervising Physician ☐ Chief Medical Officer ☐ Medical Director

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?** ☐ YES ☐ NO

5. **Please rate the applicant. If "Below Average" or "Poor", explain in detail on a separate sheet.**

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge	☐	☐	☐	☐	☐
Clinical competency	☐	☐	☐	☐	☐
Professional judgment	☐	☐	☐	☐	☐
Character and ethics	☐	☐	☐	☐	☐
Technical skills	☐	☐	☐	☐	☐
Relationships with staff	☐	☐	☐	☐	☐
Relationships with patients	☐	☐	☐	☐	☐
Cooperativeness/ability to work with others	☐	☐	☐	☐	☐

(Continued on next page)

PRINT NAME: _____

(Supervisory Evaluation Form continued)

6.	**Has the applicant's privileges to admit or treat patients <u>ever</u> been modified, suspended, reduced or revoked?** If "yes" please explain below. ☐ YES ☐ NO
7.	**Has this applicant <u>ever</u> 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.	**<u>Recommendation</u>:** ☐ Recommend for licensure in Massachusetts. ☐ Recommend for licensure in Massachusetts, with the following reservations: _____ _____ ☐ Do not recommend for the following reason(s): _____ _____

SUPERVISING PHYSICIAN SIGNATURE

Signature: _____ (*check one*) ☐ M.D. or ☐ D.O.

Print Name:_____ Date: _____ _____ _____

Title/Position: _____

E-mail:_____ Phone number:_____

RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR <u>SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL</u>.

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LIABILITY CARRIER REQUEST FORM

Applicant Print Name: _____

APPLICANT INSTRUCTIONS: **Print name above**. In **chronological order**, list your liability carriers covering the **past 10 years that you have held a full license in the U.S. or Canada**. Only include liability carriers from postgraduate training if it was within the past 10 years and you held a full license at that time. Send a copy of this form to each carrier in order to request a claims history report. Send the original form to the Board with your application.
This form is not required if you have never held a full license in the U.S. or Canada.

Liability Carrier			
Dates of Coverage	From: _____ _____ To: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	From: _____ _____ To: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	From: _____ _____ To: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	From: _____ _____ To: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	From: _____ _____ To: _____ _____	**Policy Number**	

LIABILITY CARRIER INSTRUCTIONS: Please provide the following documentation directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician's name in the subject line of the email.

Claims History Report/Loss Run Report: Please provide a claims history report on letterhead, which includes:

1. Policy number
2. Dates of policy coverage;
3. If your company's name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
    a. the name/initials of the claimant(s);
    b. nature and date of claim(s);
    c. whether the claim is pending or closed. If closed, final disposition; and
    d. amounts paid on the applicant's behalf, if any.

Additional Claim Documentation: If the applicant has a claims history, please provide copies of the following:

1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.

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NAME CHANGE AND DUPLICATE LICENSE REQUEST

INSTRUCTIONS: Complete the following information and submit copies of the required documentation to support your name change request. Return form to the attention of the Licensing Division at the above address.

NAME CHANGE INFORMATION

Former Name	**Last**	**First**	**Middle**
New Name	**Last**	**First**	**Middle**
Mailing Address	**Number and Street**		
	City	**State/Province/Territory**	**Zip (or postal) Code**
MA License #		**Date of Birth**	Month _____ Day _____ Year _____

REQUIRED DOCUMENTATION

You must submit photocopies of the following <u>two</u> required documents:

1. A current government issued photographic identification (e.g., driver license, passport, etc.); <u>AND</u>
2. One of the following additional legal documents as proof of name change:
   - ☐ Certified Court Order
   - ☐ Marriage Certificate
   - ☐ Divorce Decree

If you <u>currently</u> hold a full license in Massachusetts, you must also submit the following:

- ☐ Original wall certificate; <u>AND</u>
- ☐ Wallet sized license card.

ATTESTATION

Under the penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein and evidence submitted herewith are true, correct and complete. I understand that any falsification or misrepresentation of any item on this form or any attachment hereto may be a sufficient basis for denying or revoking a license.

SIGNATURE: _____ **DATE:** _____

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Limited License Application – International Medical Graduate – Substantial Equivalency Waiver Request Form

APPLICANT INSTRUCTIONS: If you completed more than three (3) months of clinical clerkship rotations off-site of the primary teaching hospital of your medical school of attendance you must request a waiver of substantial equivalency of medical education. The Board requires submission of this form to assist in its determination whether an applicant's course of medical school education is substantially equivalent, in its entirety, to a U.S. medical school graduate's education. If you need more space to complete the information, you may attach additional sheets as needed. Please type your answers or print clearly.

Applicant Name		**Date**	_____ _____ _____ Month Day Year

1. **Quality of Basic Science Education:** List all institutions where medical school basic science education was completed (include location of each institution):

   _____

   _____

2. **Quality of Clinical Clerkship Experience:** List all facilities where you completed clinical clerkships while in medical school.

Clerkship Area of Study	Name of Facility	Location of Facility (City/State/Country)	Number of Weeks

PRINT NAME: _____

3. **Postgraduate Training:** List all postgraduate training experience. Please include the training facility, specialty and length of the program.

_____

_____

_____

4. **Full Licensure**: List all states where you have ever held a full unrestricted medical license.

NAME OF STATE: _____ _____ _____ _____ _____

5. **Other Distinctions, Honors, Awards or Publications:**

_____

_____

_____

_____

6. **Nature and Quality of Anticipated Training Program, including degree and quality of supervision:**
Please provide the following information regarding your anticipated training in Massachusetts.

Training Facility: _____

Training Specialty: _____

Position: ☐ Internship ☐ Residency ☐ Fellowship

Training Dates: _____ _____ _____ To _____ _____ _____

PGY(s): _____

APPLICANT ATTESTATION
Under the penalties of perjury, I declare that to the best of my knowledge and belief, the information contained herein and evidence submitted herewith are true, correct and complete. I understand that any falsification or misrepresentation of any item on this form or any attachment hereto may be a sufficient basis for denying or revoking a license. **SIGNATURE: _____ _____ DATE: _____**

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Limited License Application - International Medical School - Substantial Equivalency Determination Clinical Clerkship Verification Form

APPLICANT INSTRUCTIONS: If you completed more than three (3) months of clinical clerkships off-site of the primary teaching hospital of your medical school, please complete the top section and provide this Form to your medical school for completion. This Form is required to assist the Board in its determination whether an applicant's course of medical school education is substantially equivalent, in its entirety, to a U.S. medical school graduate's education.

Applicant Print Name: _____ Date of Birth: _____ _____ _____

Name of Medical School: _____

MEDICAL SCHOOL SECTION – VERIFICATION OF CLINICAL CLERKSHIPS

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL:

- Please complete the form listing all clerkships completed by applicant and provide copies of the clerkship evaluations.
- This form must be stamped with the institutional seal or notarized on the second page.
- Return form and the clerkship evaluations to the applicant in a sealed envelope or forward directly to the Board. Please sign or stamp across the seal on the envelope.

Clerkship Subject	# of Weeks	Facility Name	Facility City/State	Was this facility the medical school's Primary Teaching Facility?	Did the Clerkship Supervisor hold a faculty appointment at the medical school?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

APPLICANT'S NAME: _____

(Substantial Equivalency – Clerkship Verification continued)

Clerkship Subject	# of Weeks	Facility Name	Facility City/State	Was this facility the medical school's Primary Teaching Facility?	Did the Clerkship Supervisor hold a faculty appointment at the medical school?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

CERTIFICATION AND SEAL

SEAL / NOTARY
If the institution does not have a seal, this form must be notarized**.**

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Signature: _____

Print Name: _____

Title: _____

Date: _____ _____ _____ Telephone: _____

E-mail address: _____

RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL OR FORWARD DIRECTLY TO THE BOARD.