Massachusetts
Board of Registration in Medicine
Supervisory Evaluation Form

Please see the form specific instructions on the attached Supervisory Evaluation and Certificate of Moral and Professional Character form.

The Physician filling out the attached forms may submit the document electronically to the Massachusetts Board of Registration in Medicine as follows:

- Use a web browser to navigate to the following URL:

- Enter the following fields exactly as they appear below:

Document Upload Code:

Applicant Last Name:

- Click the "Proceed" button

- Upload the document(s) by clicking or dragging them onto the upload

rectangular area.

Please note that once a document has been uploaded it may not be deleted.

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.

- 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 submit the form by following the instructions on the cover page.
- 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 ever been modified, suspended, reduced or revoked?** If "yes" please explain below. ☐ YES ☐ NO
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.	**Recommendation:** ☐ 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:_____

SUBMIT THE COMPLETED CERTIFICATION ELECTRONICALLY USING THE INSTRUCTIONS ON THE COVER PAGE.