**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**](http://www.mass.gov/massmedboard)

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| **SUPERVISORY EVALUATION FORM** |

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| **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: \_\_\_\_\_\_\_ |

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| **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.
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|  | **Date(s) of applicant’s affiliation at facility (month/year)?** From: \_\_\_\_\_ \_\_\_\_\_\_\_ To: \_\_\_\_\_ \_\_\_\_\_\_\_ |
|  | **In what capacity did you supervise the applicant?** [ ]  Department Chair [ ]  Chief of Service [ ]  Training Director [ ]  Supervising Physician [ ]  Chief Medical Officer [ ]  Medical Director  |
|  | **Applicant's Status:** [ ]  Intern [ ]  Resident [ ]  Fellow [ ]  Staff Member [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **Do you have any conflict of interest, personally, professionally or financially** [ ]  YES [ ]  NO**in recommending this applicant for licensure?**  |
|  | **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 |  |  |  |  |  |

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| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.** |