**Commonwealth of Massachusetts Board of Registration in Medicine**

**178 Albion Street, Suite 330 – Wakefield, MA 01880**

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[**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. | | | | | | |
|  | **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.** | |