Commonwealth of Massachusetts Board of Registration in Medicine 200 Harvard Mill Square, 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** |
| **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. | | | | | | | | |
| **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** YES NO  **in recommending this applicant for licensure?** | | | | | | | |
| **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 |  |  |  |  |  |  |  |

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PRINT NAME:

(Supervisory Evaluation Form continued)

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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.** | | | |

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