Wyoming Board of Medicine

Serving the public and practitioners since 1905

130 Hobbs Avenue, Suite A • Cheyenne, WY 82002
Phone: 307-778-7053 • Fax: 307-778-2069 • Toll free within Wyoming: 800-438-5784
Email: wyomedboard@wyo.gov • Website: http://wyomedboard.state.wy.us

Matthew H. Mead
Governor

Physician Assistant Reference Questionnaire Instruction Sheet

This instruction sheet and the questionnaire form may be duplicated as needed.

To the Applicant: Please forward one copy EACH of this instruction sheet AND the two-page Physician Assistant Reference Questionnaire to each of the three (3) practitioners who will be providing a reference on your behalf. Two (2) Reference Questionnaires MUST be from an MD or DO, the other one (1) Reference Questionnaire may be from an MD, DO or PA-C.

To the Referring Physician/Physician Assistant: This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Wyoming Board of Medicine.

____
Applicant Name

______________________________________ ______________
Applicant Signature Date

REFERRING PHYSICIAN/PHYSICIAN ASSISTANT, PLEASE NOTE: References from physicians/physician assistants with whom the applicant has a current or prospective financial, business or family relationship will not be accepted. Further, for references to be acceptable, they must meet the following criteria:

1. Must be typed or printed legibly on the Physician Assistant Reference Questionnaire form
2. Must have current date
3. Must contain the following information outlined below:
    a. Your name, address, telephone number, and professional affiliation
    b. Length of acquaintance with the applicant and in what capacity
    c. Applicant's medical acumen, experience and abilities:
        - Indicate the applicant's strengths
        - Indicate if you have ever noticed or become aware of any difficulties or shortcomings
    d. Applicant's interactions with patients, colleagues, and staff
    e. Any instances that you are aware of in which the applicant has been sanctioned in any fashion by any licensing, privileging, credentialing or academic body
    f. Any circumstances that you are aware of that might impede the applicant's ability to safely and skillfully practice medicine
    g. Must be signed and mailed directly to (FAXES WILL NOT BE ACCEPTED):

Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002

All Physician Assistant Reference Questionnaires must have an original signature; signature stamps will not be accepted. Please call if you have questions or comments: (307) 778-7053. Please feel free to add any additional comments you wish regarding this applicant. Thank you in advance for your time and assistance.

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PHYSICIAN ASSISTANT REFERENCE QUESTIONNAIRE

All responses are kept in the confidential application file
This 2-page form may be duplicated as necessary – **Please type or print legibly** – *Return by mail to the Board office (address above)*

Applicant Name: ____ Date: ______________

Name of Referring Physician/Physician Assistant:______________________________, MD/DO/PA-C

Referring Physician/Physician Assistant Specialty or Primary Area of Practice: ____________________

Address:____

City/State/Zip____

Telephone:* ____________________ E-mail:*_____________________________________

* *We often contact references to confirm information, and appreciate your cooperation in that effort.*

Using “1" (Unsatisfactory) to “5" (Outstanding), please rate this physician assistant in the following areas compared to his/her peers. If you do not have enough information to make a judgment, please indicate. Please add comments to help us understand your rating.

Subject						**Comments**
Clinical Knowledge/Judgment	1	2	3	4	5	
Technical Skill	1	2	3	4	5	
Character	1	2	3	4	5	
Communication	1	2	3	4	5	
Emotional Stability	1	2	3	4	5	
Ability to work cooperatively with others	1	2	3	4	5	
Ability to seek help from colleagues when needed	1	2	3	4	5	
Ability to respond to patients’ needs when on-call	1	2	3	4	5	
Having a respectful demeanor and sensitivity to patients’ needs	1	2	3	4	5	
Adherence to acceptable standards of professional practice	1	2	3	4	5	

Applicant Name:____

Referring Physician/ Physician Assistant Name:____________________________________, MD/DO/PA-C

OVERALL PATIENT CARE (please explain in detail any negative responses)

1. How have you known this applicant and for how long?

2. What are the physician assistant's strengths / weaknesses?

3. Has the applicant ever shown signs of any behavioral, drug or alcohol problems?

4. Has the applicant ever been a defendant in a criminal action (felony or misdemeanor)?

5. Does the applicant's health allow for the safe and competent practice of medicine?

6. Have you any knowledge of disciplinary action taken against the applicant by any medical licensing board, hospital or other healthcare facility?

7. Is there anything that this applicant needs to change to be a better physician assistant?

8. Would you have this physician assistant care for your family members and friends? Please explain.

9. If you have any concerns about this applicant, please explain.

____ _____________________________

Signature of referring physician/physician assistant Date