COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

Registration Department
Suite 5005 -- 7071 Bayers Road
Halifax, Nova Scotia
Canada B3L 2C2
Phone: (902) 422-5823 Toll-free: 1-877-282-7767
Fax: (902) 422-5035
E-mail : registration@cpsns.ns.ca
www.cpsns.ns.ca

Reference Request Form

Applicant: Please complete this section before submitting the form to your referee.

Full Name of Applicant: _____
Surname Given name(s)

Location: _____
City/Province/Country

Discipline/Specialty: _____ CPSNS Reg # _____
(If applicable)

About This Form: The person named above has applied for registration with the College of Physicians and Surgeons of Nova Scotia (College). The information you provide should be based on the applicant's demonstrated performance compared to that reasonably expected of a physician with similar levels of training and experience as the applicant. Your early response to the questions outlined below will ensure prompt consideration of the applicant's application. I accept that any and all information provided by me to the College in this reference letter may be used by the College in the course of any regulatory process of any regulatory authority, and I consent to the College disclosing this information for this purpose. I hereby consent to the College doing so.

Referee Information:

1. Are you related to the applicant? Yes ☐ No ☐
2. If "yes" in what manner? _____
3. How well do you know this physician? (Mark one)

   Not at All ☐ Not Well ☐ Somewhat ☐ Well ☐ Very Well ☐
4. Please indicate which **<u>one</u>** of the following best describes **your role** when you knew this applicant and provide the required information.
   a. Postgraduate training programme director: ☐
      i. Institution _____
      ii. City, country_____
      iii. Date applicant trained under you_____

   b. Postgraduate training supervisor or preceptor: ☐
      i. Institution _____
      ii. City, country_____
      iii. Date applicant trained under you_____

   c. Chief of Service: ☐
      i. Institution _____
      ii. City, country_____
      iii. Dates applicant practised in your institution : From: _____ To: _____
      MM/DD/YYYY MM/DD/YYYY

d. Chief of Staff or Medical Director: ◯
   i. Institution _____
   ii. City, country_____
   iii. Dates applicant practised in your institution : From: _____ To: _____
   MM/DD/YYYY MM/DD/YYYY

e. Physician Colleague: ◯
   i. Indicate which of the following apply to your working relationship with the applicant:
      ☐ A consultant to whom the applicant frequently referred patients
      ☐ A colleague in a clinic where the applicant practiced
      ☐ A colleague with whom the applicant shared on call responsibility
   ii. City, country_____
   iii. Duration of working relationship with the applicant: From: _____ To: _____
   MM/DD/YYYY MM/DD/YYYY

f. Other: ◯
   i. Please describe your role when you knew this applicant:

   ii. City, country_____
   iii. Duration of working relationship with the applicant: From: _____ To: _____
   MM/DD/YYYY MM/DD/YYYY

Candidate Information:

5. **Clinical Practice**: Please provide your opinion of the applicant, within the range of services they provided and in comparison to their peers, with respect to the following:

	Among the worst	Bottom Half	Average	Top Half	Among the Best	Unable to Assess
Communicates effectively with patients and families	◯	◯	◯	◯	◯	◯
Establishes respectful relationships with nursing and other healthcare professional staff	◯	◯	◯	◯	◯	◯
Establishes respectful relationships with physician colleagues	◯	◯	◯	◯	◯	◯
Demonstrates appropriate clinical knowledge and competence	◯	◯	◯	◯	◯	◯
Makes the correct diagnosis in a timely fashion	◯	◯	◯	◯	◯	◯
Demonstrates appropriate judgment	◯	◯	◯	◯	◯	◯
Performs technical procedures skilfully	◯	◯	◯	◯	◯	◯
Creates medical record and patient related documentation that is accurate, organized, and completed in a timely manner	◯	◯	◯	◯	◯	◯

Please provide any comment or explanation regarding your answers:

6. **Professional Ethics:** Do you consider the applicant to be:

	Yes	No	Insufficient knowledge of candidate to answer
Reliable	◯	◯	◯
Ethical	◯	◯	◯
Of good character	◯	◯	◯

Please provide explanations of any "No" answers, above:

7. **Professional Conduct:**

a. To your knowledge, has the applicant ever engaged in:

	Yes	No
Fraud or dishonesty	◯	◯
Unprofessional conduct	◯	◯
Excessive use of alcohol or other mood altering substances?	◯	◯

If "yes" please provide an explanation:

b. To your knowledge, has the applicant ever experienced any of the following:

	Yes	No
Failure of any part of training	◯	◯
Discipline by hospital or training programme	◯	◯
Loss of privileges or staff appointment	◯	◯
Discipline by licensing authority	◯	◯

If "yes" please provide an explanation:

8. **Additional Information:**

a. Would you refer your patients or family members to this applicant? Yes ☐ No ☐
If "no" please provide an explanation:

b. Please provide any other comments or information you feel important to include.

c. In completing this reference form, all referees agree to discuss the contents of this form and/or provide further details if required, by telephone with the Registrar or designate. You must provide the phone number and best time to contact you:

Phone number(s): _____ or _____
Best days of the week and time to call:_____

Referee: Please complete this section before forwarding the form to the CPSNS

Full Name of Referee: _____
Surname Given name(s)

Address: _____
Full Mailing Address

Discipline/Specialty:_____

E-mail: _____

Date form completed: _____
MM/DD/YYYY

Please return the completed form directly to the College of Physicians & Surgeons of Nova Scotia by fax**: (902) 422-5035** or by e-mail: **registration@cpsns.ns.ca.**