THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

REFERENCE FORM

This evaluation should be based on demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience and professional background as the applicant. Please complete all parts of this form.

Full Name of Applicant: _____

CPSO File # (if known): _____

Section 1: REFEREE INFORMATION

Full Name: _____

Primary Site of Practice: _____

Current Position / Title: _____

a) Is the applicant related to you? ↑ Yes ____ No ____

b) Do you work in the same location as applicant? Yes ____ No ____

c) In what capacity do you currently work with the applicant?

Program Director _____ Chief of Staff _____ Department/Division Head _____

Senior Colleague _____ Medical Director _____ Nurse _____

d) Are you presently in a position of formal authority over the applicant's work? ↑ Yes____ No____

If No, please explain: _____

e) How long have you worked with the applicant? From _____ / _____ To _____ / _____
Month / Year Month / Year

f) Name of hospital/clinic/university where you presently work with the applicant? _____

_____

Section 2: APPLICANT INFORMATION

Description of the applicant's medical activities:

_____

_____

_____

_____

_____

In your experience working with the applicant, please rate the applicant in the following competencies with any concerns related to the applicant noted in section H:

a) Medical Expert

	Above Average	Average	Below Average	Unknown
Basic scientific knowledge				
Basic clinical knowledge				
History and physical examination				
Orders test appropriately				
Interpretation and utilization of information				
Clinical judgment and decision making				
Technical skills required in the specialty				
Overall performance				

b) Communicator

	Above Average	Average	Below Average	Unknown
Interprofessional relationships with physicians				
Communication with other allied health professionals				
Communication with patients				
Communication with families				
Written communication & documentation				

c) Collaborator

	Above Average	Average	Below Average	Unknown
Asks for referrals appropriately to physicians and non-physicians				
Interacts and consults effectively with health professionals by recognizing and acknowledging their roles and expertise				
Delegates effectively				

d) Leader

	Above Average	Average	Below Average	Unknown
Understands and uses information technology				
Uses health care resources cost-effectively				
Organization of work and time management				

e) Health Advocate

	Above Average	Average	Below Average	Unknown
Advocates for the patient				
Advocates for the community				

f) Scholar

	Above Average	Average	Below Average	Unknown
Motivation to read and acquire knowledge				
Critically appraises medical literature				
Teaching skills				
Completion of research/project				

g) Professional

	Above Average	Average	Below Average	Unknown
Integrity and honesty				
Sensitivity and respect for diversity				
Responsibility and self-discipline				
Communicates with patients with compassion and empathy				
Recognition of own limitations, seeking advice when needed				
Understands principles of ethics: applies to clinical situations				
Understands boundary issues/ethical limits				

h) Strengths and Areas of Improvement

What are the applicant's greatest strengths?

What areas of improvement and development have been identified for the applicant?

i) Other

Do you have any additional information with respect to this applicant which may be relevant to his/her application for registration to practice medicine in Ontario?

Section 3: SUMMARY RECOMMENDATION

RECOMMEND WITHOUT RESERVATIONS ☐

RECOMMEND WITH RESERVATIONS ☐

DO NOT RECOMMEND ☐

If recommending with reservations or do not recommend, please explain:

_____

_____

_____

_____

_____

_____

Please email / call me to discuss this applicant Yes ____ No ____

E-mail: _____

Phone number: (_____) _____ - _____

Best time to call : _____

Full Name: _____

Title: _____

Signature: _____ Date: _____ / _____ / _____

Reference forms sent by the applicant are not acceptable. The referee must return the completed form directly to the College:

1. Scanned copy by email to credentials@cpso.on.ca, or
2. By mail, in an official or stamped envelope to:

   The College of Physicians and Surgeons of Ontario
   Applications and Credentials Department
   80 College Street, Toronto, Ontario M5G 2E2

Thank you for taking the time to complete the reference form. If you have any questions, please contact Registration Inquiries at (416) 967-2617, Monday through Friday 9am to 5pm (EST).

Rev. Jan/2017