



REQUIREMENT 3

Adherence to Ethical and Professional Standards

REFEREE CHECKLIST

***Note for electronic use:** Before filling out this form, please be sure to disable the “Auto Complete” feature in Adobe. Select “Preferences,” under menu item “Edit.” Click on “Forms” on the left side of the Preferences box. Select “Off” for “Auto Complete.”

APPLICANT: Please provide this form to each recommending physician.

You must have a minimum of **two (2)** checklists from physicians licensed to practice allopathic or osteopathic medicine, who can accurately and honestly attest to the nature and scope of your practice in Pain Medicine. Each reference should be accompanied by a brief letter on the referring physician’s professional letterhead, summarizing the nature and duration of his/her professional relationship with you.

Only one (1) checklist from a physician who practices within your clinic, practice, group, or corporation will be considered. Checklists from trainees, employees, relatives or spouses will not be considered.

If you practice in a multispecialty clinic, practice, group, or corporation comprising at least 50 physicians, such as a teaching hospital or large clinic, one checklist can be from a physician who practices within your functional area (eg, department, division) and the second may be either from a physician practicing in a functional area that is distinctly different from yours, or from a physician practicing outside your clinic, practice, group or corporation.

NOTE TO RECOMMENDING PHYSICIAN: The physician listed below is applying for recertification by the American Board of Pain Medicine. As a recommending physician, you have been asked to complete this checklist that speaks about the applicant’s practice in Pain Medicine. Please complete the following form, providing your signature on the back of the form. In evaluating the applicant’s performance, please use as your standard the level of knowledge, skills and attitudes expected of a clearly satisfactory physician.

For any component that is rated unsatisfactory, please provide specific comments and recommendations on the back of the form. Please be as specific as possible, including reports of critical incidents and /or outstanding performance.

I. LETTER OF INTRODUCTION

IMPORTANT: A brief letter on your professional letterhead, summarizing the nature and duration of your professional relationship with the applicant and addressed to our Credentials Committee, must be attached to this form.

II. Regarding: Dr. _____

To the best of your knowledge, was this practitioner ever subject to any disciplinary action such as admonition, reprimand, suspension, restriction or denial of privileges, or termination? Yes No

To the best of your knowledge, does the practitioner suffer from any physical, mental, substance use or emotional problems that affect his/her ability to perform in a professional capacity? Yes No

If the answer to either of the above questions is *yes*, please provide detailed information on page 2.

III. PERFORMANCE EVALUATION

	Superior	Satisfactory	Unsatisfactory
Clinical Knowledge			
Clinical Judgment			
Technical Proficiency			
Professional Relations with Patients			
Ethical Conduct			
Recordkeeping			

IV. Does this applicant practice comprehensive Pain Medicine? Yes No

V. Please feel free to add any comments regarding this practitioner’s performance, character, or suitability for certification by the American Board of Pain Medicine.

SIGNATURE

Name (Please Type or Print Legibly)

Signature

Title/Institution

Date

Address

Address