DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

PROFESSIONAL REFERENCE FORM

The District of Columbia Board of Podiatry evaluates the qualifications of applicants for licensure to practice as podiatrist in the District of Columbia.

The applicant named below has applied for a license to practice as a podiatrist and has listed you as a reference to his/her character. Your assistance with this evaluation will assist the Board when considering this applicant for licensure and is greatly appreciated**. Please return this form directly to the Board at the address or email provided at the bottom of the second page.**

Applicant Name: _____

Applicant's Address: _____

I HEREBY CERTIFY THE FOLLOWING:
Professional relationship with applicant: _____
Approximate length of time known applicant:_____Years_____Months

Are you aware of any personal traits, habits, or conduct which would make the applicant unsuitable to be licensed as a podiatrist: _____Yes _____No

If yes, please explain_____

To your knowledge, is the applicant free from mental defects and/or drug habits:____Yes__No

If no, please explain_____

Please evaluate Applicant's performance by indicating with a check*:

	N/A**	POOR	FAIR	GOOD	SUPERIOR
Professional knowledge	☐	☐	☐	☐	☐
Clinical Judgment	☐	☐	☐	☐	☐
Relationship with patients	☐	☐	☐	☐	☐
Ethical/professional conduct	☐	☐	☐	☐	☐
Dependability	☐	☐	☐	☐	☐
Ability to communicate	☐	☐	☐	☐	☐

*For any attribute checked Fair or Poor, please elaborate in part 4.
**Unable to evaluate

2. Recommendation for licensure (Please indicate with check):

1. Recommend highly without reservation ☐
2. Recommend as qualified and competent ☐
3. Recommend with some reservation (explain below) ☐
4. Do not recommend (explain below) ☐

3. This evaluation is based on (Please indicate with check):

1. Close personal observation ☐
2. General impression ☐
3. A composite of evaluations ☐
4. Other (Please specify below) ☐

4. Relationship to applicant (Please indicate with check):

1. Program Director ☐
2. Immediate Supervisor ☐
3. Other (Please specify below) ☐

4. Please give any additional information, which you feel would aid the Board in determining the qualifications of the applicant (Please use a separate sheet if necessary):

_____

_____

_____

_____

_____ _____
Name of Evaluator (Please Print or Type) Date

_____
Signature of Evaluator

_____
Title of Evaluator

Board of Podiatry Address: 899 North Capitol St. NE
Washington, DC 20002

Board Email Address: dcbopod@dc.gov