Dear Referee,

Thank you for taking the time to complete this form. Please ensure all the sections of this form are filled out for the District Health Board and Medical Council processes.

You may wish to save your report for this candidate in your files, as this form can be used for all District Health Boards and the Medical Council.

|  |  |  |
| --- | --- | --- |
| **CANDIDATE DETAILS** | | |
| Family name |  | |
| Given name(s) |  | |
| How long have you been supervised by this referee?  (specific months required) | From: 00 / 20XX | Comments: |
| To: 00 / 20XX |

|  |  |
| --- | --- |
| **REFEREE DETAILS** | |
| Family name |  |
| Given name(s) |  |
| Phone |  |
| Email |  |
| Position / title |  |
| Place of work where you worked with the applicant |  |
| Medical qualifications |  |
| Supervision | I hold full vocational registration as a Specialist |
| Relationship to candidate | I confirm I have supervised this candidate clinically on a day-to-day basis |
| If you are related to/in a relationship with the candidate, please declare the nature of the relationship:  ……………………………………………………………….  (Leave blank if not applicable) |
| Dates of candidate supervision |  |
| How long have you known the candidate? |  |
| Is English your first language? | Yes  No |
| The basis on which I am making my assessment of this candidate: | Firsthand knowledge/direct observation  Information from colleagues  Information from other medical staff  Other (describe)  ……………………………………………………………….  ……………………………………………………………….  ………………………………………………………………. |