Postgraduate

**Physician Assistant Mental Health Residency**

VA Medical Center

Attn: Sherry S. Marin, PA-C

17273 State Route 104

Chillicothe, Ohio 45601

SUBJ: Solicitation for Reference

Dear Sir, Miss, or Madam,

This applicant is applying for admission to the Postgraduate Physician Assistant Mental Health Residency program at VA Medical Center in Chillicothe, Ohio. Information on the enclosed questionnaire is requested to be utilized in the admissions decision process. We ask that you assess this applicant’s current clinical practice and provide your opinion of his or her ability to perform as a PA in the specialty of mental health and working with veterans at this VA Medical Center.

We are requesting 3 references total. For PAs who have been working clinically within 5 years prior to application: a supervising/collaborating physician who supervised actual clinical practice, a PA peer, and another medical professional who knows the applicant’s clinical practice. For new PA graduates with no clinical practice: 1 or 2 references from the PA program faculty and a personal reference is familiar with the applicant’s potential to succeed in this residency program.

This document is considered *PRIVILEGED AND CONFIDENTIAL*. Release of this information is protected under the Privacy Act.

Enclosed is the Reference questionnaire. Please complete and mail this application to the VA Medical Center address as noted above. Your cooperation in this matter is greatly appreciated. If you have any questions, please contact me at (740) 773-1141, ext. 6234 or 7886.

Sincerely,

Dr. Sherry S. Martin, DHSc, PA-C, CAQ Psychiatry

PA Mental Health Residency Program Director

[Sherry.Martin@va.gov](mailto:Sherry.Martin@va.gov)

**APPLICANT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**A. RELATIONSHIP OF REFERENCE SOURCE TO APPLICANT**

1. Do you personally know the applicant? Checkbox: Do you personally know the applicant? YES Yes Checkbox: Do you personally know the applicant? NO No

If so, how long have you known the applicant? \_\_\_\_\_\_\_\_\_\_ months/years (circle one)

1. What type affiliation have you experienced Checkbox: What type of affiliation have you experienced with the applicant? PERSONAL Personal Checkbox: What type of affiliation have you experienced with the applicant? HOSPITAL Hospital  
   with the applicant? Checkbox: What type of affiliation have you experienced with the applicant? PRACTICE Practice Checkbox: What type of affiliation have you experienced with the applicant? PROGRAM DIRECTOR Program Director  
    Checkbox: What type of affiliation have you experienced with the applicant? OTHER Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If *Hospital* affiliation, please provide dates  
    of membership on your staff. Beginning Date Hospital Affiliation Beginning Date

Ending Date Hospital Affiliation Ending Date

1. Did you have an opportunity to directly observe Checkbox: Did you have an opportunity to directly observe the applicant practice? YES Yes Checkbox: Did you have an opportunity to directly observe the applicant practice? NO No  
   the applicant practice?

NO

Daily Weekly Monthly INFORMATION

1. How frequently did you observe? Checkbox: Daily observation Checkbox: Weekly observation Checkbox: Monthly observation Checkbox: No information concerning observation
2. Do you have any concern of the applicant’s clinical Checkbox: Did you have an opportunity to directly observe the applicant practice? YES Yes Checkbox: Did you have an opportunity to directly observe the applicant practice? NO No  
   qualifications and current clinical competency?
3. Would you recommend this applicant for the residency? Checkbox: Did you have an opportunity to directly observe the applicant practice? YES Yes Checkbox: Did you have an opportunity to directly observe the applicant practice? NO No

**B. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE**

**Please rate as excellent (Ex), good, average (Avg), below average (BA), or unable to evaluate (UE).** *If you do not have adequate knowledge to answer a particular question, please indicate “Unable to Evaluate (UE)”*

***Medical/Clinical knowledge***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| * Basic medical/clinical knowledge | | Checkbox: Basic medical/clinical knowledge EXCELLENT Ex | Checkbox: Basic medical/clinical knowledge GOOD Good | | Checkbox: Basic medical/clinical knowledge AVERAGE Avg | | Checkbox: Basic medical/clinical knowledge BELOW AVERAGE BA | Checkbox: Basic medical/clinical knowledge UNABLE TO EVALUATE UE |
| * Knowledge in specialty | | Checkbox: Knowledge in specialty EXCELLENT Ex | Checkbox: Knowledge in specialty GOOD Good | | Checkbox: Knowledge in specialty AVERAGE Avg | | Checkbox: Knowledge in specialty BELOW AVERAGE BA | Checkbox: Knowledge in specialty UNABLE TO EVALUATE UE |
| * Technical and clinical skills | | Checkbox: Technical and clinical skills EXCELLENT Ex | Checkbox: Technical and clinical skills GOOD Good | | Checkbox: Technical and clinical skills AVERAGE Avg | | Checkbox: Technical and clinical skills BELOW AVERAGE BA | Checkbox: Technical and clinical skills UNABLE TO EVALUATE UE |
| ***Clinical judgment*** | |  |  | |  | |  |  |
| * Basic clinical judgment | | Checkbox: Basic clinical judgment EXCELLENT Ex | Checkbox: Basic clinical judgment GOOD Good | | Checkbox: Basic clinical judgment AVERAGE Avg | | Checkbox: Basic clinical judgment BELOW AVERAGE BA | Checkbox: Basic clinical judgment UNABLE TO EVALUATE UE |
| * Availability and thoroughness of patient care | | Checkbox: Availability and thoroughness of patient care EXCELLENT Ex | Checkbox: Availability and thoroughness of patient care GOOD Good | | Checkbox: Availability and thoroughness of patient care AVERAGE Avg | | Checkbox: Availability and thoroughness of patient care BELOW AVERAGE BA | Checkbox: Availability and thoroughness of patient care UNABLE TO EVALUATE UE |
| * Appropriate and timely use of consultants | | Ex | Good | | Checkbox: Appropriate and timely use of consultants AVERAGE Avg | | Checkbox: Appropriate and timely use of consultants BELOW AVERAGE BA | UE |
| * Quality / appropriateness of patient care outcomes | | Checkbox: Basic medical/clinical knowledge EXCELLENT Ex | Checkbox: Basic medical/clinical knowledge GOOD Good | | Checkbox: Basic medical/clinical knowledge AVERAGE Avg | | Checkbox: Basic medical/clinical knowledge BELOW AVERAGE BA | Checkbox: Basic medical/clinical knowledge UNABLE TO EVALUATE UE |
| * Appropriate use of resources | | Checkbox: Knowledge in specialty EXCELLENT Ex | Checkbox: Knowledge in specialty GOOD Good | | Checkbox: Knowledge in specialty AVERAGE Avg | | Checkbox: Knowledge in specialty BELOW AVERAGE BA | Checkbox: Knowledge in specialty UNABLE TO EVALUATE UE |
| * Clinical pertinence and completeness of documentation | | Checkbox: Technical and clinical skills EXCELLENT Ex | Checkbox: Technical and clinical skills GOOD Good | | Checkbox: Technical and clinical skills AVERAGE Avg | | Checkbox: Technical and clinical skills BELOW AVERAGE BA | Checkbox: Technical and clinical skills UNABLE TO EVALUATE UE |
|  | |  |  | |  | |  |  |
| ***Communication skills*** | |  |  | |  | |  |  |
| * Overall communication skills with patients | | Checkbox: Overall communication skills with patients EXCELLENT Ex | Checkbox: Overall communication skills with patients GOOD Good | | Checkbox: Overall communication skills with patients AVERAGE Avg | | Checkbox: Overall communication skills with patients BELOW AVERAGE BA | Checkbox: Overall communication skills with patients UNABLE TO EVALUATE UE |
| * Verbal and written fluency in English | | Checkbox: Verbal and written fluency in English EXCELLENT Ex | Checkbox: Verbal and written fluency in English GOOD Good | | Checkbox: Verbal and written fluency in English AVERAGE Avg | | Checkbox: Verbal and written fluency in English BELOW AVERAGE BA | Checkbox: Verbal and written fluency in English UNABLE TO EVALUATE UE |
| * Clarity/legibility of records | | Checkbox: Clarity/legibility of records EXCELLENT Ex | Checkbox: Clarity/legibility of records GOOD Good | | Checkbox: Clarity/legibility of records AVERAGE Avg | | Checkbox: Clarity/legibility of records BELOW AVERAGE BA | Checkbox: Clarity/legibility of records UNABLE TO EVALUATE UE |
| * Responsiveness to patient needs | | Checkbox: Responsiveness to patient needs EXCELLENT Ex | Checkbox: Responsiveness to patient needs GOOD Good | | Checkbox: Responsiveness to patient needs AVERAGE Avg | | Checkbox: Responsiveness to patient needs BELOW AVERAGE BA | Checkbox: Responsiveness to patient needs UNABLE TO EVALUATE UE |
|  | |  |  | |  | |  |  |
| ***Interpersonal skills*** | |  | | | | | | |
| Ability to work with members of healthcare team | | Checkbox: Ability to work with members of healthcare team EXCELLENT Ex | Checkbox: Ability to work with members of healthcare team EXCELLENT Good | | Checkbox: Ability to work with members of healthcare team EXCELLENT Av | | Checkbox: Ability to work with members of healthcare team EXCELLENT BA | Checkbox: Ability to work with members of healthcare team EXCELLENT UE |
| * Rapport with hospital staff | | Checkbox: Ability to work with members of healthcare team EXCELLENT Ex | Checkbox: Ability to work with members of healthcare team GOOD Good | | Checkbox: Ability to work with members of healthcare team AVERAGE Avg | | Checkbox: Ability to work with members of healthcare team BELOW AVERAGE BA | Checkbox: Ability to work with members of healthcare team UNABLE TO EVALUATE UE |
| * Rapport with patients | | Checkbox: Rapport with patients EXCELLENT Ex | Checkbox: Rapport with patients GOOD Good | | Checkbox: Rapport with patients AVERAGE Avg | | Checkbox: Rapport with patients BELOW AVERAGE BA | Checkbox: Rapport with patients UNABLE TO EVALUATE UE |
| * Rapport with families | | Checkbox: Rapport with families EXCELLENT Ex | Checkbox: Rapport with families GOOD Good | | Checkbox: Rapport with families AVERAGE Avg | | Checkbox: Rapport with families BELOW AVERAGE BA | Checkbox: Rapport with families UNABLE TO EVALUATE UE |
|  | |  |  | |  | |  |  |
| ***Professionalism*** | |  | | | | | | |
|  |  |  |  |  | |  |
| * Timely documentation of medical record | | Checkbox: Timely documentation of medical record EXCELLENTEx | Checkbox: Timely documentation of medical record GOOD Good | | Checkbox: Timely documentation of medical record AVERAGE Avg | | Checkbox: Timely documentation of medical record BELOW AVERAGE BA | UE |
| * Participation in medical staff organization activities (e.g. committees, leadership positions) | | Checkbox: Participation in medical staff organization activities EXCELLENTEx | Checkbox: Participation in medical staff organization activities GOOD Good | | Checkbox: Participation in medical staff organization activities AVERAGE Avg | | Checkbox: Participation in medical staff organization activities BELOW AVERAGE BA | Checkbox: Participation in medical staff organization activities UNABLE TO EVALUATE UE |
| * Participation in continuing medical education | | Checkbox: Participation in continuing medical education EXCELLENTEx | Checkbox: Participation in continuing medical education GOOD Good | | Checkbox: Participation in continuing medical education AVERAGE Avg | | Checkbox: Participation in continuing medical education BELOW AVERAGE BA | Checkbox: Participation in continuing medical education UNABLE TO EVALUATE UE |
| * Demonstration of ethical standards in treatment | | Checkbox: Demonstration of ethical standards in treatment EXCELLENTEx | Checkbox: Demonstration of ethical standards in treatment GOOD Good | | Checkbox: Demonstration of ethical standards in treatment AVERAGE Avg | | Checkbox: Demonstration of ethical standards in treatment BELOW AVERAGE BA | Checkbox: Demonstration of ethical standards in treatment UNABLE TO EVALUATE UE |
| * Maintenance of patient confidentiality | | Checkbox: Maintenance of patient confidentiality EXCELLENTEx | Checkbox: Maintenance of patient confidentiality GOOD Good | | Checkbox: Maintenance of patient confidentiality AVERAGE Avg | | Checkbox: Maintenance of patient confidentiality BELOW AVERAGE BA | Checkbox: Maintenance of patient confidentiality UNABLE TO EVALUATE UE |
| * Fulfillment of clinical call responsibility | | Checkbox: Fulfillment of clinical call responsibility EXCELLENTEx | Checkbox: Fulfillment of clinical call responsibility GOOD Good | | Checkbox: Fulfillment of clinical call responsibility AVERAGE Avg | | Checkbox: Fulfillment of clinical call responsibility BELOW AVERAGE BA | Checkbox: Fulfillment of clinical call responsibility UNABLE TO EVALUATE UE |

**C. ADDITIONIAL INFORMATION**

# YES NO NO INFORMATION

1. Have you ever observed or been informed of any physical, mental, Checkbox: Question 1 YES Checkbox: Question 1 NO Checkbox: Question 1 NO INFORMATION  
   health/drug, or alcohol dependencies, emotional, behavioral or other   
   problems which could potentially affect his/her ability to perform the  
   duties of a PA Resident?
2. To the best of your knowledge, has the applicant been involved in Checkbox: Question 2 YES Checkbox: Question 2 NO Checkbox: Question 2 NO INFORMATION  
   any administrative, professional, or judicial proceedings in which   
   professional malpractice on his/her part was alleged (including   
   cases brought, pending, settled, or decided)?
3. To the best of your knowledge, has the applicant ever been Checkbox: Question 3 YES Checkbox: Question 3 NO Checkbox: Question 3 NO INFORMATION  
   convicted of a crime other than a minor traffic violation?
4. To the best of your knowledge, has the applicant’s *professional* Checkbox: Question 4 YES Checkbox: Question 4 NO Checkbox: Question 4 NO INFORMATION *liability insurance* ever been voluntarily or involuntarily terminated?
5. To the best of your knowledge, has there ever been a substantiated Checkbox: Question 5 YES Checkbox: Question 5 NO Checkbox: Question 5 NO INFORMATIONallegation that the practitioner’s behavior interfered with the

performance of the health care team?

1. To the best of your knowledge, has the applicant ever provided care Checkbox: Question 6 YES Checkbox: Question 6 NO Checkbox: Question 6 NO INFORMATIONor attempted to provide care to patients while under the influence

of drugs, alcohol, or controlled substance?

7. To the best of your knowledge, have any of the following ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn from or resignation submitted, suspended, revoked, modified, placed on probation, relinquished, or voluntarily surrendered, or such actions that are pending?

# YES NO NO INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| * License, registration, or certification | Checkbox: License, registration, or certification YES | Checkbox: License, registration, or certification NO | Checkbox: License, registration, or certification NO INFORMATION |
| * Clinical privileges | Checkbox: Clinical privileges YES | Checkbox: Clinical privileges NO | Checkbox: Clinical privileges NO INFORMATION |
| * Hospital appointment | Checkbox: Hospital appointment YES | Checkbox: Hospital appointment NO | Checkbox: Hospital appointment NO INFORMATION |
| * Affiliation with any healthcare organization | Checkbox: Affiliation with any healthcare organization YES | Checkbox: Affiliation with any healthcare organization NO | Checkbox: Affiliation with any healthcare organization NO INFORMATION |
| * Professional status/society membership | Checkbox: Professional status/society membership YES | Checkbox: Professional status/society membership NO | Checkbox: Professional status/society membership NO INFORMATION |
| * Employment or contract arrangement with any healthcare facility | Checkbox: Employment or contract arrangement with any healthcare facility YES | Checkbox: Employment or contract arrangement with any healthcare facility NO | Checkbox: Employment or contract arrangement with any healthcare facility NO INFORMATION |
| * Employment or contract arrangement with a physician group | Checkbox: Employment or contract arrangement with a physician group YES | Checkbox: Employment or contract arrangement with a physician group NO | Checkbox: Employment or contract arrangement with a physician group NO INFORMATION |
| * Prerogative/rights on a medical staff | Checkbox: Prerogative/rights on a medical staff YES | Checkbox: Prerogative/rights on a medical staff NO | Checkbox: Prerogative/rights on a medical staff NO INFORMATION |
| * Any other type of professional sanction | Checkbox: Any other type of professional sanction YES | Checkbox: Any other type of professional sanction NO | Checkbox: Any other type of professional sanction NO INFORMATION |

If you responded YES to any of the previous items, please explain:

**D. SUMMARY**

RECOMMEND

WITHOUT NOT

RESERVATION RECOMMEND RECOMMEND

1. My general recommendation concerning Checkbox: Recommend Without Reservation Checkbox: Recommended Checkbox: Not Recommended  
this applicant is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please use this section for any additional comments, information, or recommendations which you believe would be relevant to our decision to accept to this applicant for post-graduate PA Mental Health Residency.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed

Signature Date (mmddyyyy)

Signee Printed Name

## Printed Name

Signee TitleSignee Phone Number

## Title Phone Number