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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

Postgraduate Trainee Reference Request

Applicant information

Applicant to complete this section before submitting to their references.

Applicant Last Name: _____ Given/First Name: _____

City, Province: _____ CPSA Tracking Number: CPSA.P_____

Discipline/specialty: _____

References

The person named above has applied for registration with the College of Physicians & Surgeons of Alberta (CPSA) while they undergo a program of postgraduate training in Alberta. CPSA regulates physicians and physician assistants in Alberta, Canada and is responsible for registering physicians and physician assistants and issuing practice permits. The content of this form is confidential. CPSA will not share your responses with the applicant or any third party, and will only use this information to help assess this application.

1. Are you related to the applicant? ☐ Yes ☐ No

   If **yes**, please state your relationship: _____

2. How well do you know this physician? (choose one)
   ☐ Not at all ☐ Not well ☐ Somewhat ☐ Well ☐ Very well

3. Please indicate which **one** of the following seven options best describes **your role** when you knew this applicant and provide the required information:

   ☐ Undergraduate advisor
   ☐ Undergraduate preceptor
   ☐ Postgraduate training program director
   ☐ Postgraduate training preceptor/supervisor
   ☐ Supervisor of the applicant in a non-educational, non-training or non-practising role:

   Indicate which of the following apply to your professional relationship with the applicant:

   ☐ Supervisor of the applicant during a clinical observership
   ☐ Supervisor of the applicant during employment as a Clinical, Surgical, Clinical/Surgical, or Medical Research Assistant
   ☐ Supervisor of the applicant during employment in a non-physician role in a clinical office or medical research project

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☐ Clinic colleague

Indicate which of the following apply to your professional relationship with the applicant:

- ☐ A consultant to whom the applicant frequently referred patients
- ☐ A colleague in a clinic where the applicant practised medicine
- ☐ A coleague whith whom the applicant shared on-call responsibility

☐ Other

Describe your role when you knew this applicant:

City, Country (in which you worked with the applicant: _____

Duration of working relationship with the applicant: From: _____ To: _____

ASSESSMENT OF APPLICANT

4. Professional ethics

Do you consider the applicant to be:

	Yes	No	Insufficient knowledge of candidate to answer
Reliable	☐	☐	☐
Ethical	☐	☐	☐
Of good character	☐	☐	☐

Please explain any "no" answers above:

5. Professional conduct:

   a. To your knowledge, has the applicant ever engaged in:

	Yes	No
Fraud or dishonesty	☐	☐
Unprofessional conduct	☐	☐
Excessive use of alcohol or other mood altering substances	☐	☐

Please explain any "yes" answers above:

   b. To your knowledge, has the applicant ever experienced any of the following:

	Yes	No
Failure of any part of training	☐	☐
Discipline by hospital or training program	☐	☐
Loss of privileges or staff appointment	☐	☐
Discipline by licensing authority	☐	☐

Please explain any "yes" answers above:

6. Additional information

   Please provide any other comments or information you feel are important to include:

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Reference information

Reference Last Name: _____ Reference First Name: _____

City, Province: _____ Country: _____

Email: _____ Telephone: _____

Discipline/specialty: _____

Thank you for acting as a reference on behalf of the applicant. **Your responses are confidential.** CPSA **will not** share your responses with the applicant or any third party, and will only use this information to assess the application.

Signature: _____ Date: _____

Submit

Please return the completed form to CPSA. If you are unable to sign electronically and use the submit function, please email us the signed document at registration@cpsa.ab.ca.