Name of applicant for CCPM “Membership”:
Name of physician and institution:

Number of years you have known the applicant:
Physician registration number:
Size of comparison group:

Please provide your assessment of the applicant in the following areas:

1. Professional attitudes and communication skills:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Unsatisfactory | Adequate | Good | Very Good | Outstanding |
| Interpersonal Skills | ☐ | ☐ | ☐ | ☐ | ☐ |
| Initiative | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sense ofresponsibility | ☐ | ☐ | ☐ | ☐ | ☐ |
| Adaptability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Oral and written skills | ☐ | ☐ | ☐ | ☐ | ☐ |

1. Clinical experience with the applicant:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Unable to assess | Demonstrates lack of knowledge and/orexperience | Demonstrates some knowledge and/or experience | Demonstrates good knowledge and/or experience |
| Interaction withapplicant | ☐ | ☐ | ☐ | ☐ |
| Discussion pertaining to patient-related issues (e.g. patient positioning, dose distribution, imagequality, etc.) | ☐ | ☐ | ☐ | ☐ |
| Discussion pertaining to (or participation in) a clinical researchproject | ☐ | ☐ | ☐ | ☐ |
| Knowledge ofequipment selection and evaluation | ☐ | ☐ | ☐ | ☐ |

1. Evaluation of the applicant

In the space provided or on a separate sheet, please comment on the following items with respect to the applicant:

* + Your confidence in the clinical physics-related advice received from the applicant
	+ General comments on the strengths and weaknesses of the applicant as a clinical medical physicist.

I recommend the applicant for Membership in the CCPM (check one)

Yes ☐ No ☐ Unable to Assess ☐

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referee’s signature:

Send this form, **as a PDF**, to: info@ccpm.ca