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 of  responsibility | ☐ | ☐ | ☐ | ☐ | ☐ |
| Adaptability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Oral and written skills | ☐ | ☐ | ☐ | ☐ | ☐ |

1. Clinical experience with the applicant:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Unable to assess | Demonstrates lack of knowledge and/or  experience | Demonstrates some knowledge and/or experience | Demonstrates good knowledge and/or experience |
| Interaction with  applicant | ☐ | ☐ | ☐ | ☐ |
| Discussion pertaining to patient-related issues (e.g. patient positioning, dose distribution, image  quality, etc.) | ☐ | ☐ | ☐ | ☐ |
| Discussion pertaining to (or participation in) a clinical research  project | ☐ | ☐ | ☐ | ☐ |
| Knowledge of  equipment 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](mailto:info@ccpm.ca)