

CaRMS 2018 Referee Assessment Form

Applicant Name: _____ **CaRMS No:** _____

Thank you for serving as a reference. In choosing residents for our Anesthesia Program, our Selection Committee places a good deal of emphasis on the information provided by medical faculty who have observed the applicant in the clinical setting. We kindly request your input in this questionnaire. The program asks you to please complete this form **in addition** to a formal personalized letter of reference. This form may be mailed to CaRMS with your reference letter or completed and uploaded as a pdf to the CaRMS website along with your reference letter.

Please rate the applicant on the following competencies:

	Exceptional Top 3%	Excellent Top 15%	Above Average Top 25%	Average Top 50%	Below Average	Unable To Assess
Medical Expert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Collaborator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Advocate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leader	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scholar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suitability to Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check one of the following:

- I would *highly* recommend this applicant without reservation
- I would recommend this applicant without reservation
- I would recommend this applicant
- I would **not** recommend this applicant for Anesthesia residency

Referee Name: _____

Title/Position: _____

Signature: _____

Date: _____