



MEDICAL BOARD OF TRINIDAD AND TOBAGO

ERIC WILLIAMS MEDICAL SCIENCES COMPLEX

Uriah Butler Highway, Champs Fleurs, TRINIDAD, W.I.

Phone: (868) 645-2640/2650 Ext. 5830 or 645-5223 (Direct)

RECOMMENDATION FOR FULL REGISTRATION WITH THE MEDICAL BOARD OF TRINIDAD & TOBAGO OF A DOCTOR WHO HAS A TEMPORARY LICENCE

To: Secretary Medical Board

Name of applicant: _____ Qualifications _____

(Dates and Place)

Present Status: _____

He/She has held the following post/posts under my supervision:

DATE	ROTATION	DATE	ROTATION

An evaluation of his/her overall performance is as follows:

A	KNOWLEDGE OF ENGLISH			
	Comprehension	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Communication Skills	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Clear, Accurate, Legible and Comprehensive Notes	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>

B	PROFESSIONAL SKILLS & CLINICAL COMPETENCE			
	History Taking	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Examination/Investigation	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Management	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Treatment	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Relevant Use of Resources	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>

C	DEPARTMENT/ATTITUDES			
	To Patient	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	To Other Members of the Team	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>

D	ATTENDANCE/PUNCTUALITY	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
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P.T.O.

E	CONTINUING PROFESSIONAL DEVELOPMENT			
	Knowledge	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Practical Procedures	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>
	Research Capabilities	Good <input type="checkbox"/>	Adequate <input type="checkbox"/>	Poor <input type="checkbox"/>

F	Comments:
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G	Overall Assessment of Competence	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Average <input type="checkbox"/>	Poor <input type="checkbox"/>
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I, **DR.** _____ of _____
am a member of the Medical Board of Trinidad and Tobago and am in good standing. I have known the
applicant for _____ years and I consider him/her a fit/unfit person to attain Full Registration with the
Medical Board of Trinidad and Tobago.

Date: _____

Signature: _____

Position: _____

NB: THIS IS A CONFIDENTIAL REPORT TO BE SENT TO THE MEDICAL BOARD OF TRINIDAD & TOBAGO. PLEASE PUT OFFICIAL STAMP ON SIGNATURE AS VERIFICATION.