New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Respiratory Care
124 Halsey Street, 6th Floor, P.O. Box 45031
Newark, New Jersey 07101
(973) 504-6485

Out-of-State Verification of Medical Employment

(This form is to be completed by the applicant's most recent employer(s).)

Employer: Please attach the facility's letterhead and/or business card to this form and send it directly to the Board.

Applicant's Name: _____

Employer's Name: _____

Employer's Address:_____

Employer's Telephone Number:_____

1. What position did the above individual hold when employed by you? _____

   _____

2. What were his/her dates of employment? From_____ To _____
3. Did he or she leave your employment in good standing? ☐ Yes ☐ No
4. Was this individual on probation, suspended, sanctioned or disciplined while employed by you? ☐ Yes ☐ No
5. Was this individual granted a leave of absence while employed by you? ☐ Yes ☐ No
6. Were any restrictions placed on his or her activities which were not placed on all other employees holding similar positions?
   ☐ Yes ☐ No
7. Were any incident reports filed involving the professional conduct or behavior of this individual? ☐ Yes ☐ No
8. Was he or she ever subject to nonroutine monitoring while in your employ? ☐ Yes ☐ No
9. Was this individual subject to nonroutine quality assessment review? ☐ Yes ☐ No
10. Did quality assessment review of this individual ever result in a negative finding? ☐ Yes ☐ No
11. Were any malpractice actions filed naming this health practitioner as a defendant that involved his or her period of employment at your facility? ☐ Yes ☐ No
12. Would you consider employing this health practitioner again? ☐ Yes ☐ No
13. Would you recommend this health practitioner for privileges at your facility? ☐ Yes ☐ No

    If you answered "No" to questions number 3, 12 or 13, or "Yes" to questions number 4 through 11, please explain._____

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Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure. _____

_____

_____

Print the name of the employer supplying information:_____

Signature of the employer supplying information:_____

Date form was completed :_____

NOTE: COPIES OR FAXES OF THE REQUIRED LETTERHEAD OR BUSINESS CARD WILL NOT BE ACCEPTED AS ORIGINAL DOCUMENTS.

Once you have completed this form, please email the form to: RespiratoryCare@dca.njoag.gov

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