Clinical Apprenticeship Scheme

Reference Request Form – CONFIDENTIAL

PART 1: CANDIDATE DETAILS		
Name of candidate		
PART 2: REFEREE DETAILS		
Name		
Job title		
Postal address		
Email address		
PART 3: REFERENCE		
Dates of when you worked with the Doctor		
In what professional capacity do you know the Doctor?		
In what capacity did you work with the Doctor?		
How long have you known the Doctor in this capacity?		
Please comment on the Doctor's clinical abilities		
Please give observations on the Doctor's relationship with and communication skills with patients		
Please comment on:		

General conduct	
Time keeping	
Number of days/occasions off sick and reason for absence	
Team work	
Honesty and integrity	
Please give your detailed comments on this Doctor's suitability to be offered a supernumerary post.	

PART 3: SIGNATURE	
Signed:	Date:
Name:	

Please note: the information provided on this form will be stored in a database. However your information will not be shared with any other organisation.

Please return COMPLETED/SIGNED to:	
Coordinator – CAPS Professional Support Unit Professional Development Stewart House 32 Russell Square London WC1B 5DN	Email: CAPS.Lase@hee.nhs.uk Tel: +44 (0) 20 7866 3265 http://www.lpmde.ac.uk/training-programme/training-matters/international-medical-graduates/foundation-project-for-refugee-doctors-caps

FOR OFFICE ONLY	
Date received:	Database entry: