



New Jersey Office of the Attorney General

Division of Consumer Affairs

State Board of Medical Examiners

140 East Front Street, 3rd Floor, P.O. Box 183

Trenton, New Jersey 08625

(609) 826-7100

Bio-analytical Lab Director Employment Verification Form

Applicant's Name: _____

Laboratory Name: _____

Laboratory Address: _____

Laboratory Telephone: () _____

Supervisor's Name: _____

Supervisor's Title: _____

1. What position did this individual hold when employed by you? _____
2. What were this individual's dates of employment? From _____ to _____
3. Was this a full time position? Yes No
- 3a. If part-time, please indicate hours per week: _____
4. Was the individual on probation, suspended or in any way sanctioned/disciplined while employed by you? Yes No
5. Were any restrictions placed on this individual's activities which were not placed on all other employees holding similar positions? Yes No
6. Was this individual ever subject to non-routine monitoring while in your employ? Yes No
7. Was this individual subject to non-routine quality assessment review? Yes No
8. Did quality assessment review of this individual ever result in a negative finding? Yes No
9. Did this individual leave your employ in good standing? Yes No
10. Were any incident reports filed involving the professional conduct or behavior of this individual? Yes No
11. Were any malpractice actions filed naming this individual as a defendant based on actions that occurred during the period of employment by you? Yes No
12. Would you consider re-hiring this individual? Yes No
13. Would you recommend this individual? Yes No

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

Please supply a detailed description of the professional activities of this individual while in your employ. Include all phases of benchwork in which the employee participated as well as the supervisory duties assigned to the employee.

Please print name of supervisor supplying information: _____

Signature of supervisor supplying information: _____

Date form was completed: _____

Please attach letterhead from the facility where the applicant worked or supply some form of identification for individual supplying information.

Please return directly by email to:

Bmeapp@dca.njoag.gov

The email should include a signature with the name and title of the person authorized to submit the form on behalf of the employer.