**VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING**

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| **Section I: Verification of training and performance during training**  **(*To be completed for EACH trainee)*** |
| Trainee’s Full Name:Click here to enter text. | DOB:Click here to enter text. | NPI:Click here to enter text. |
| Program Specialty or Subspecialty:[ ] Preliminary Program: Click here to enter text. Date From/To: Click here to enter text.[ ] Core Residency Program: Click here to enter text. Date From/To: Click here to enter text.[ ] Fellowship Program: Click here to enter text. Date From/To: Click here to enter text. |
| Training Program Accreditation: [ ]  ACGME [ ]  AOA [ ] OtherIf marked “other,” please indicate accreditation type or list “none:” Click here to enter text.Program ID #: Click here to enter text. |
| Did the above-named trainee successfully complete the training program which she/he entered? [ ]  Yes [ ]  NoIn addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.*(If NO, please provide an explanation in the “Additional Comments” section below or enclose a separate document.)* |
| Was the trainee subject to any of the following during training?1. Observation or probation; [ ] Yes [ ]  No
2. Leave of absence/break from training; [ ]  Yes [ ]  No
3. Suspension; [ ]  Yes [ ]  No
4. Non-promotion/non-renewal; or [ ]  Yes [ ]  No
5. Dismissal. [ ]  Yes [ ]  No
 |
| Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision. [ ]  Yes [ ]  No [ ]  N/A*(If NO, please provide an explanation in the “Additional Comments” section below or enclose a separate document.)* |
| Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty’s board certification examination? [ ]  Yes [ ]  No [ ]  N/AIf NO, indicate the reason(s):[ ]  This trainee was a preliminary resident.[ ]  Trainee was not eligible for certification.[ ]  Trainee involuntarily or voluntarily left this program before completion.\*[ ]  No certification is available for this subspecialty.[ ]  Other.\*\**Please provide an explanation in the “Additional Comments” section below or enclose a separate document.* |

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| **Section II: Additional Comments** |
| Please utilize this comment area to provide additional information in response to any of the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*Click here to enter text. |

Supplemental Information

UNUSUAL CIRCUMSTANCES:

1. Did this individual resign from training? [ ]  Yes [ ]  No
2. Were any limitations or special requirements placed upon this individual for professionalism or behavioral issues? [ ]  Yes [ ]  No
3. Did this individual ever receive a written warning or documented counseling about her/his

behavior? [ ]  Yes [ ]  No

VERIFICATION OF PROFESSIONAL HISTORY

1. Do you consider the applicant:
	1. Reliable? [ ]  Yes [ ]  No
	2. Ethical? [ ]  Yes [ ]  No
	3. Of good character? [ ]  Yes [ ]  No

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| --- | --- | --- | --- |
| Excellent | Good | Average | Poor |
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1. Please rate the applicant:
2. Professional ability
3. Attention to duties
4. Breadth of education
5. Interpersonal Skills
6. Has applicant, to your knowledge, ever been guilty of:
	1. Fraud or dishonesty? [ ]  Yes [ ]  No
	2. Unprofessional conduct? [ ]  Yes [ ]  No
7. To your knowledge, has the applicant ever:
	1. Been warned, censured, reprimanded, disciplined, had addmissions monitored or privileges

limited or suspended? [ ]  Yes [ ]  No

* 1. Had disciplinary action taken against him/her by a licensing agency?[ ]  Yes [ ]  No
	2. Been denied or surrendered a federal or state controlled substance

permit? [ ]  Yes [ ]  No

* 1. Been arrested, fined, charged with or convicted of a crime, indicted

imprisoned or placed on probation? [ ]  Yes [ ]  No

* 1. Been a defendant in a legal action involving professional liability

or had a professional liability claim paid in her/his behalf or paid such

a claim her/himself? [ ]  Yes [ ]  No

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| **Section III: Attestation** |
| The information provided on this form is based on review of available training records and evaluations.Signature: Printed Name: Click here to enter text.GME Title: Click here to enter text.Phone Number: Click here to enter text.Email: Click here to enter text.Date Form Completed: Click here to enter text. |