**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 Other  If 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  No  In 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/A  If 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. |