Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: ______________________________________ Date: ______________

Print or Type Name: ______________________________________

Name of Institution: ______________________________________

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: ______________________________________

If name of Institution was different when applicant attended, please enter name:

____

Enrollment and Participation: Our records indicate that______________________________ participated in the following program:
(Print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited

(Continued on page 2)

APPLICANT'S NAME:____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?	☐	☐
2. Was the applicant ever placed on probation?	☐	☐
3. Was the applicant ever disciplined or under investigation?	☐	☐
4. Were any negative reports ever filed by instructors regarding the applicant?	☐	☐
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☐

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☐ ACGME ☐Other:____________________

COMMENTS;____

____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: ____

Print Name: ____

Academic Title: ____

Telephone: (_____)_________________ Today's Date: ____/_____/_______

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.