UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #2)

Institution Name: ______________________________

Institution Address: ______________________________

____

Affiliated School: ______________________________

Applicant: Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

Program Director or designated Official: Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

Section 1:
To be completed by the Applicant.

Name: ______________________ **Suffix** ______ **Practitioner type: M.D.** ☐ **D.O.** ☐

Date of birth: ____________ **(mm/dd/yyyy)** **SSN*** ______________________

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Name if different when diploma awarded: ______________________

Board Information:
To be completed by the applicant.

Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:

Board Name: Idaho State Board of Medicine
Mailing address: 11341 W Chinden Blvd. Building 4 Boise, ID 83714

Applicant Please Sign Here →

Applicant Signature ______________________ **Date** ____________

Section 2 :
Program Participation :

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Report Internships, Residencies and Fellowships separately.

Training Level: ______ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed? ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ______ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ______ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: ______________________
From: __/__/____ **To:** __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper.
Attach pages as needed.

1. Did this individual ever take a leave of absence or break from his/her training? ---------------- ☐ Yes ☐ No
2. Was this individual ever placed on probation? ---------------- ☐ Yes ☐ No
3. Was this individual ever disciplined or placed under investigation? ---------------- ☐ Yes ☐ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ---------------- ☐ Yes ☐ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ---------------- ☐ Yes ☐ No

Certification: Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate and complete statement of the record of the individual named on this form. This section MUST be signed by the program director (M.D. or D.O. only). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature: ______________________

Print name: ______________________

Title: ______________________

Email address: ______________________

Phone Number: ______________________ **Date:** ____________