Cover Letter 2

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING
CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

[Date]

Re:
[Name of Trainee]
[DOB or NPI]
[Residency or fellowship program]
[Training Dates 1]
[Training Dates 2 (if applicable)]

[Hospital or credentialing organization]
[Department/Program]
[Organization]
[Address 1]
[Address 2]
[City, State, Zip]

Dear [Hospital or credentialing organization] :

The above-referenced physician trained at this institution in this program and during the dates referenced above. The enclosed Verification of Graduate Medical Education Training Form summarizes this individual's performance during that period of training.

This form:
_____was completed at the time the trainee left the program,

or

_____was completed by the current program director, based on a review of the trainee's file, after the trainee had left the program, and is sent to you upon receipt of a signed authorization and release form by the former trainee.

This cover letter attests that the enclosed information contains a complete and accurate summary of the trainee's performance in this program. We are unable to provide information about training or practice after completion of this program, and trust that you will obtain that information from the appropriate programs/institutions.

Sincerely,
[Program Director or Institutional Official]
[Title]
[Organization]
[Address 1]
[Address 2]
[City, State, Zip]

Enclosures: (i) Verification of Graduate Medical Education & Training Form

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING

Section I: Verification of training and performance during training
(To be completed for EACH trainee)

Trainee's Full Name:	DOB:	NPI:

Program Specialty or Subspecialty:

☐Preliminary Program: _____ Date From/To: _____
☐Core Residency Program: _____ Date From/To: _____
☐Fellowship Program: _____ Date From/To: _____

Training Program Accreditation: ☐ ACGME ☐ AOA ☐Other

If marked "other," please indicate accreditation type or list "none:"

Program ID #: _____

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?

(i) Conditions or restrictions beyond those generally associated with the training regimen at your facility; ☐Yes ☐ No

(ii) Involuntary leave of absence; ☐ Yes ☐ No

(iii) Suspension; ☐ Yes ☐ No

(iv) Non-promotion/non-renewal; ☐ Yes ☐ No

(v) Dismissal; or ☐ Yes ☐ No

(vi) Resignation. ☐ Yes ☐ No

(If YES to any of the above, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Upon completion of the training program, the individual was deemed to have demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; (Core)

☐ 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.*

If you wish to include a photo of the resident, please upload here.

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.)*

Section III: Attestation

The information provided on this form is based on review of available training records and evaluations.

Signature: _____

Printed Name: _____

GME Title: _____

Professional Credentials: _____

Phone Number: _____

Email: _____

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training (VGMET)" Form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form).This VGMET Form is then time-stamped and inserted into the trainee's file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program's verification of training. The form will not include detailed lists of current procedural or technical competencies.

NOTE: THE VGMET FORM IS NOT INTENDED TO MEET REQUIREMENTS FOR LICENSURE. PLEASE USE THIS SUPPLIED FORM FROM THE FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) FOR LICENSURE PURPOSES. THIS CAN BE USED WHETHER THE PHYSICIAN IS USING FCVS OR IS SEEKING LICENSURE INDEPENDENTLY.