STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF RESIDENCY TRAINING FORM

Applicant: Enter your full name and birth date on this form and forward it to the Chief of Staff or Program Director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's Name: _____ Date of Birth: _____

Chief of Staff/Program Director: Please provide the following verification of residency training for the above named Connecticut physician licensure applicant.

1. Name of facility where residency training was completed: _____

2. Dates of participation: From _____ To _____
   (month/day/year) ***(month/day/year)***

3. In what specialty was the residency training completed:_____

4. At what level(s) was this residency completed **(PGY1, PGY2, etc.)**?_____

5. At the time of the individual's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or The Royal College of Physicians and Surgeons of Canada (RCPSC)? **_____ (YES or NO)**

6. Did this individual satisfactorily complete this period of residency training? **_____ (YES or NO)***

7. Was this individual ever placed on probation? **_____ (YES or NO)***

8. Was this individual ever disciplined or placed under investigation? **_____ (YES or NO)***

9. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? **_____ (YES or NO)***

If you answered" No" to question 6 or "Yes" to questions 7-9, please provide details and or attach any documents you may have on file regarding such information.

I, _____, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: _____

Address: _____

_____

Telephone Number: (_____) _____ Email: _____

I certify that the information above is an accurate account of the individual's record and is true and correct.

_____ _____
Signature of Chief of Staff/Program Director ***Date***

Please return this form directly to:

Connecticut Department of Public Health
Physician Licensure
410 Capitol Ave, MS#12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1931