NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Verification of Post-Graduate Training

Instructions to Applicant:

1. Please complete Sections I and III(Make sure you include the address of your department in Section III).

2. Please forward this document to **all** institutions where you obtained residency or fellowship training. (If you trained at more than one institution, please copy this form as many times as necessary.) Any fee that is charged is your responsibility.

3. Submission of this completed form is the responsibility of the applicant.

Section I: To be Completed by Applicant

____

Last Name, First Name Middle Name Maiden Name

______________________________ ______________________________

Social Security Number Date of Birth

______________________________ ______________________________

Signature Date

Program Name____

Dates of Training ____

Institution Where Training Provided____

Mailing Address ____

____

Section II: To be Completed By Institutional Official or Program Director

Please complete this section, sign the certifying statement and return to the address indicated below.

Dates of Training ____
(Month/day/year) to (month/day/year)

Program Name ____

ACGME Approved __(Yes/No)____

Program Completed Satisfactorily_(Yes/No) __________________________________
(If no, please provide explanation)
Was the trainee recommended for Board Certification in this specialty_(Yes/No)_____________
(if no, please provide explanation)

____
Signature, Program Director or Institutional GME Official

____
Printed Name, Program Director or Institutional GME Official

PLEASE DO NOT COMPLETE UNTIL PROGRAM REQUIREMENTS ARE FULFILLED

Section III: Forwarding Information(to be completed by Applicant)

Forward completed form to:

NewYork –Presbyterian Hospital
Graduate Medical Education Office
525 East 68th Street, Box #312
New York, NY, 10065