

PRIMARY SOURCE VERIFICATION COMPLETION FORM

To be completed by Residency Program Coordinator/Director:

Applicant Name: _____
Applicant Start Date: _____ PGY Level: _____
Residency Program: _____
References: <i>(Letters from ERAS application or those recieved directly from the reference are acceptable.)</i>
1. _____ Reviewed on/by: _____
2. _____ Reviewed on/by: _____
3. _____ Reviewed on/by: _____
Curriculum Vitae Reviewed on/by: _____
Any lapse in time thoroughly explained by applicant (explanation): _____

To be completed by GME Office:

Medical School Graduation Verified on _____ by _____ <i>(Must be a letter mailed directly from the Medical School to the GME Office or ECFMG Status Report if FMG)</i>
Verification Received from Prior Training (if applicable):
Training Site: _____ Verified on/by: _____
ECFMG Certification Verification Service (if applicable):
ECFMG/USMLE ID#: _____
Verified by: _____ Date: _____
Licensure: (If applicable, every state where a professional license in health care field was issued.)
State: _____ Verified by: _____ Date Verified: _____ Type of License: _____
Any Restrictions/Actions: _____
State: _____ Verified by: _____ Date Verified: _____ Type of License: _____
Any Restrictions/Actions: _____
If Previously Licensed: Date of query National Practitioner Data Bank (NPDB): _____
Date of query results: _____