

Washington Medical Commission
 P.O. Box 47866
 Olympia, WA 98504-7866
 360-236-2750

Postgraduate Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name _____

Address _____

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the postgraduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print or type)	Birth date (mm/dd/yyyy)
Signature of applicant	

To be completed by the facility/agency/program:

1. _____ is or was engaged in postgraduate training in our
Applicant Name (Print or type)
 program _____

from Beginning date (month/year) _____ to Ending date (month/year) _____
 in the field of _____

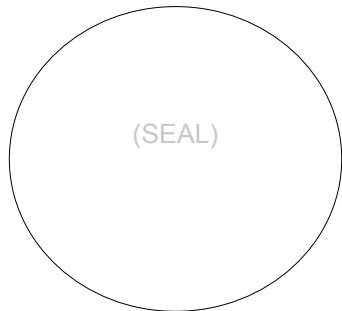
2. At the time this individual was in training, was this program accredited through the accreditation council for graduate medical education, the Royal College of Physicians and Surgeons, or the college of family Physicians of Canada? Yes No

If no, does this program qualify the applicant to become board certified? Yes No

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? Yes No

If yes, please explain _____

4. Did this applicant successfully complete this training program? Yes No
 in process OR expected date of completion _____



Signature _____

Title _____

Email _____

Address _____

Date _____ Phone _____

Return directly to the address listed above