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 _____

(SEAL)

Signature _____

Title _____

Email _____

Address _____

_____

Date _____ Phone_____

**Return directly to the address listed above**