Washington State Department of Health

MD

TO: Post Graduate Training Program Director

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FACILITY NAME

____
ADDRESS

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RE: Verification/Evaluation of Training

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 post-graduate 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 below. **All questions must be answered.**

______________________________ ______________________________
APPLICANT (PRINT OR TYPE) BIRTHDATE

______________________________ ______________________________
SIGNATURE OF APPLICANT

1. ______________________________ is or was engaged in postgraduate training in our program

from ______________________________ to ______________________________
BEGINNING DATE (MONTH & YEAR) 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

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

If yes, please explain ______________________________

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Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature ______________________________

Title ______________________________

Hospital ______________________________
PLEASE TYPE OR PRINT

Address ______________________________

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Date ______________________________

Telephone ______________________________