STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

VERIFICATION OF MEDICAL RESIDENCY TRAINING

APPLICANT: Enter your full name and birth date on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's Name:_____ Date of Birth:_____

Dear Chief of Staff/Program Director:

Please provide the following **verification of residency training** for the above-named Connecticut physician licensure applicant.

Name of facility where residency training was completed: _____

Dates of Residency: From_____ To_____
(month/day/year) **(month/day/year)**

In what specialty was the residency training completed:_____

At what level(s) was this residency completed **(PGY1, PGY2, etc.)**?_____

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? **_____ (YES or NO)**

Did the applicant satisfactorily complete this period of residency training?**_____ (YES or NO)**

Do you have **any derogatory** information **regarding** the competency or conduct of **this applicant**?_____ If yes, please attach any disclosable documents you may have on file regarding such information.

I, _____, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: _____

Address: _____

_____

Telephone Number: _____

Email: _____

and that the information provided herein is true and correct to the best of my knowledge and belief.

_____
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this _____ day of _____ (month/ year)_____

_____ _____
Notary Public's Signature My Commission Expires

Please return this form directly to:

Department of Public Health
Homeopathic Physician Licensure
410 Capitol Ave., MS # 12 APP
P.O. Box 340308
Hartford, CT 06134-0308