

University of Michigan School of Public Health

Preventive Medicine Residency Program

Residency Verification Form

The physician named below has applied to the Preventive Medicine Residency Program at the University of Michigan. Your institution was named as one where he/she has trained. Could you please complete this form and mail or fax directly to:

Matthew Boulton, MD, MPH
Director, Preventive Medicine Residency
University of Michigan School of Public Health
109 Observatory
Ann Arbor, MI 48109-2029

Tel: (734) 764-6478
Fax: (734) 764-9293

****Information in this box is to be completed by residency applicant before sending to Program Director.****

Residency applicant's name _____

Program Director's name _____

Institution _____

Institution phone _____

Institution address _____

I request a CONFIDENTIAL evaluation be sent to the University of Michigan and waive my right to review this evaluation.

I request a NON-CONFIDENTIAL evaluation be sent to the University of Michigan and retain my right to review this evaluation.

 Residency Applicant's Signature Date

 Residency Applicant's Signature Date

You **must** sign one of the above choices **before** requesting your Program Director to complete this evaluation form.

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which the physician participated, providing starting and ending dates of his/her training in you program and type of training and whether credit was given for the training.

Dates	Specialty	Credit	No Credit	Partial Credit
PGY 1				
PGY 2				
PGY 3				
PGY 4				
Fellowship				
Other				

- | | <u>Yes</u> | <u>No</u> |
|---|------------|-----------|
| 2. Was the residency/fellowship accredited by ACGME of the AMA? | _____ | _____ |
| 3. Was the residency/fellowship accredited by ACGME of the AOA? | _____ | _____ |
| 4. Did the physician complete the full training in good standing?
If no, please attach explanation on a separate sheet. | _____ | _____ |
| 5. Was the physician asked to or required to repeat any portion of the training at your facility?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 6. Was the physician placed on probation, suspended or in any way sanctioned/disciplined?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 7. Was this physician recommended for the Board Certification examination in this specialty? | _____ | _____ |
| 8. Was this physician granted a leave of absence while training at your facility?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 9. Did this individual have a record of any unexcused absences during his/her attendance at this training program? | _____ | _____ |
| 10. Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 11. Were any formal patient or staff complaints filed against this physician?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 12. Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 13. Was this physician ever subject to non-routine monitoring while at your facility?
If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 14. Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet. | _____ | _____ |
| 15. Is there any additional information in this physician's file that would assist us in determining this physician's eligibility for our residency program?
If yes, please attach explanation on a separate sheet. | _____ | _____ |

Additional comments:

Print name of Program Director _____

Signature of Program Director _____

Date form was completed _____