ATTACHMENT 2

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384

VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

APPLICANT: Provide the information requested in the top box and then mail this form to each institution in which you received any postgraduate medical training. If additional forms are required, copy this one.

Institution Administration: I am applying for a Tennessee medical license and hereby authorize you to release any and all information in your files concerning my medical training. I was in training at your institution as follows:

Applicant's name: _____
(Last) (First) (Middle/Maiden)

Name of Institution: _____ **Program Title:** _____

_____ _____
Applicant's Signature **Dates**

THIS PORTION IS TO BE COMPLETED BY THE TRAINING PROGRAM'S ADMINISTRATIVE OFFICE

Please complete (including questions) and return to:

State of Tennessee
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243

	CIRCLE ONE	
Is your training program currently ACGME approved?	Yes	No
Was the above program LCME/ACGME approved at the time the applicant completed training?	Yes	No
Were there any adverse charges or actions taken during the residency? If yes, please attach supporting information and/or documentation.	Yes	No
Would you recommend the applicant for licensure?	Yes	No
Did the applicant successfully complete the program?	Yes	No

The applicant attended the program from _____ (Mo/Yr) to _____ (Mo/Yr). I certify that the information on this form is true and correct.

_____ _____
Program Director's/Dean's Signature Date

Subscribed and sworn before me this the ____ day of _____, _____.

_____
Notary Public (Affix Seal Here)

My Commission Expires: