Applicant: *Each institution where internship, residency and/or fellowship training was received must complete this form; If more than one institution was attended, photocopies of this blank form may be made and used.*

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF POSTGRADUATE TRAINING

Institution: ______________________ Affiliated University: ______________________

Address: ____

Name of Physician: ____

DOB: __________ SSN/ITIN#: ______________ Medical School: ______________________

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The following information is to be completed by postgraduate training program only.

IMPORTANT – Program Participation:

- Report incomplete postgraduate years (PGY) separately from those that were successfully completed.
- If the postgraduate year is currently "In Progress", report the expected completion in the "To" field.
- Report Internships, Residencies and Fellowships separately.

PG/Year: ☐ **DEPARTMENT / SPECIALTY:** ______________________

☐ **Internship** **From:** ______________ **To:** ______________
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

PG/Year: ☐ **DEPARTMENT / SPECIALTY:** ______________________

☐ **Internship** **From:** ______________ **To:** ______________
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

PG/Year: ☐ **DEPARTMENT / SPECIALTY:** ______________________

☐ **Internship** **From:** ______________ **To:** ______________
☐ **Residency**
☐ **Fellowship** **Successfully Completed?** ☐ **Yes** ☐ **No** ☐ **In Progress**
☐ **Research**

Unusual Circumstances: Indicate the correct response to the questions below.
"Yes" responses require written explanation.

1. Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME) or Coordinating Council of Medical Education (CCME) of the Canadian Medical Association? ☐ **Yes** ☐ **No**
2. Did this individual ever take a leave of absence or break from their training? If yes, please explain. ☐ **Yes** ☐ **No**
3. Was this individual disciplined and/or placed under investigation or on probation? ☐ **Yes** ☐ **No**

Please explain below any "Yes" response(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

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I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

This section MUST be signed by the Program Director (M.D. or D.O. only)

Signature by personnel other than an M.D. or D.O. must attach an authorization letter.

Name: ______________________ ☐ **M.D.** ☐ **D.O.** Title: ______________________

Signature: ______________________ Date of Signature: ______________

Telephone: ______________ Fax: ______________ E-mail: ______________

Completed form is to be mailed by the verifying institution directly to:
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89521

Training Program: *If you have questions, you may contact the Board at (775) 688-2559. The Board requires that this verification form be received by mail and NOT by facsimile.*