UC DAVIS HEALTH

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING

Section I: Verification of training and performance during training
(To be completed for EACH trainee)

Trainee's Full Name:	DOB:	NPI:

Program Specialty or Subspecialty:

☐ Preliminary Program: _____ Date From/To: _____

☐ Core Residency Program:_____ Date From/To: _____

☐ Fellowship Program: _____ Date From/To: _____

Training Program Accreditation: ☐ACGME ☐AOA ☐Other

If marked "other," please indicate accreditation type or list "none:"

Program ID #: _____

Did the above-named trainee successfully complete the training program which she/he entered?
☐Yes ☐No

In addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Was the trainee subject to any of the following during training?

(i) Conditions or restrictions beyond those generally associated with the training regimen at your facility; ☐ Yes ☐No

(ii) Involuntary leave of absence; ☐ Yes ☐No

(iii) Suspension; ☐ Yes ☐No

(iv) Non-promotion/non-renewal; or ☐ Yes ☐No

(v) Dismissal. ☐ Yes ☐No

Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision.

☐ Yes ☐ No ☐ N/A

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty's board certification examination? ☐ Yes ☐ No ☐ N/A

If NO, indicate the reason(s):

☐ This trainee was a preliminary resident.

☐ Trainee was not eligible for certification.

☐ Trainee involuntarily or voluntarily left this program before completion. *

☐ No certification is available for this subspecialty.

☐ Other. *

**Please provide an explanation in the "Additional Comments" section below or enclose a separate document.*

Section II: Additional Comments

Please utilize this comment area to provide additional information in response to any of the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*

Section III: Attestation

The information provided on this form is based on review of available training records and evaluations.

Signature:

Printed
Name:

GME Title:

Phone
Number:

Email:

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training (VGMET)" form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form). This group has also been working with the Federation of State Medical Boards (FSMB) to address the needs for licensure within the form and will continue that work. This VGMET is then time-stamped and inserted in the trainee's file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program's verification of training. The form will not include detailed lists of current procedural or technical competencies.