

CONFIDENTIAL VERIFICATION AND REFERENCE

This confidential document relating to a former resident is provided to you by the University of Michigan Department of _____ Residency Program. We submit this document in response to your request for verification of residency training and reference information in lieu of other forms. The contents of this document are provided with the permission of the physician identified below and is not to be released to any other party without the consent of that physician.

Name: _____

Social Security Number: _____

Program: _____

Verification of Training:

Dr. _____ received training in the Department of _____ at the University of Michigan during the following period(s):

_____	_____
_____	_____
_____	_____

Disciplinary Action:

During the dates of training provided above, Dr. _____ (see attachment) was not subject to any institutional disciplinary action.

Professional Liability:

- ☐ To the best of our knowledge, Dr. _____ was not investigated by any government agency or other legal body and was not the defendant in any malpractice suit during residency training.
- ☐ See attached details.

Ability to Practice Medicine:

Training requirements set forth by the Accreditation Council for Graduate Medical Education for board eligibility were met:

- ☐ Satisfactorily
- ☐ Unsatisfactorily

Evaluation:

The following table is based on the demonstrated performance during residency training, personal observation by members of the Department of _____ and a composite of multiple evaluations by supervisors.

	Unsatisfactory	Satisfactory	Superior	No Knowledge
Basic Medical Knowledge				
Professional Judgement				
Sense of Responsibility				
Ethical Conduct				
Clinical Competence				
Technical Skills				
Cooperativeness, Ability, to work with others				
Record Keeping				
Patient Management				
Physician/Patient Relationship				
Ability to Understand and Speak English				

Comments:

Recommendation:

- ☐ Based on a composite evaluation by the program resident evaluation committee, Dr. _____ is recommended for medical practice in _____.

Program Director

- ☐ I have reviewed this evaluation with the program director to designee. I understand that this form will, in most cases, be utilized as the confidential verification and reference form in lieu of other forms when requests for verification of resident training and/or reference are received by the Department of _____.

Resident Physician

- ☐ Resident refused to sign.

I attest that the forgoing information is true in every respect.

Program Director

Date



Seal