Guidelines for Standard Residency Verification Letters

Wisconsin Northern & Central GME Consortium (WiNC)

Initial GMEC Approval:	06-09-20
Last GMEC Review Date:	

Scope

This policy pertains to all WiNC-sponsored residency/fellowship programs. The term resident/residency is used synonymously with fellow/fellowship unless otherwise specified. (GMEC approved 10/20/2022)

Purpose

To provide common definitions for "conditions or restrictions beyond those generally associated with the training regimen at your facility" on the Standard Residency Verification Letter (attached).

Guidelines

1. The following situations would generally be considered "conditions or restrictions beyond those generally associated with the training regimen at your facility":
    a. Academic Probation
    b. Extension of residency (reasons including but not limited to: leave of absence, reduced FTE, educational plan with extension, etc.)
2. The following situations would generally NOT be included in this definition:
    a. Educational plan without extension of residency
    b. Restrictions on responsibilities associated with usual progression through the program. For example, may be promoted from the PGY1 to the PGY2 year but may not be approved to supervise other residents.
    c. Substance abuse monitoring contract
    d. Resident accommodations (unless resulting in residency extension)

Verification of Graduate Medical Education Training

BACKGROUND AND INSTRUCTIONS

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association of Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training" (VGMET). 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.

The VGMET form has three sections:

- **Section One**: Verification of graduate medical education training. Completed for all.
- **Section Two:** Additional comments as needed.
- **Section Three:** Attestation.

The form would be completed **once** by the program director at the time of completion of the internship, residency or fellowship (separate form for each training program completed).

The signed form would be placed in the trainee's file. The form would be photocopied and sent with Cover Letter 2 (see below) to hospitals or other organizations requesting verification of training.

The current program director (often not the PD at the time of graduation) would review the file and complete the form based on information contained therein. He/she would sign and date the form and send to the requesting hospital with Cover Letter 2 (see below).

Thereafter, that form would be used in response to all requests for training verification – a photocopy of the form, and a signed dated cover letter attesting that the form accurately reflects information about the trainee in the file.

If former graduate requests a verification of training and a letter is not on file, one will be generated and will be put in their file for future requests.

Cover Letter 1

CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

[Date]

[Residency Program Director]
[Organization]
[Address 1]
[Address 2]
[City, State, Zip]

Re: [Name of Trainee]
[DOB or NPI]

Dear Dr. [Residency Program Director Name]:

The above-referenced individual has applied for medical staff appointment and/or clinical privileges at [name of requesting entity]. This individual has indicated that he/she received training at your institution.

Your assistance in completing the enclosed form is greatly appreciated. Please fax or e-mail the completed form to [name of requesting department] at [facsimile #] and [e-mail address of requesting entity]. The individual named above has signed the enclosed authorization and release form that authorizes you to provide this information.

Should you have any questions, please contact this department at [requesting department phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Name]

[Title]

Enclosures: (i) Verification of Graduate Medical Education Training Form
(ii) Authorization and Release Form

Cover Letter 2

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING
CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

[Date]

Re:
[Name of Trainee]
[DOB or NPI]
[Residency or fellowship program]
[Training Dates 1]
[Training Dates 2 (if applicable)]

[Hospital or credentialing organization]
[Department/Program]
[Organization]
[Address 1]
[Address 2]
[City, State, Zip]

Dear [Hospital or credentialing organization]:

The above-referenced physician trained at this institution in this program and during the dates referenced above. The enclosed Verification of Graduate Medical Education Training Form summarizes this individual's performance during that period of training.

This form:
____ was completed at the time the trainee left the program,

or

____ was completed by the current program director, based on a review of the trainee's file, after the trainee had left the program, and is sent to you upon receipt of a signed authorization and release form by the former trainee.

This cover letter attests that the enclosed information contains a complete and accurate summary of the trainee's performance in this program. We are unable to provide information about training or practice after completion of this program, and trust that you will obtain that information from the appropriate programs/institutions.

Sincerely,

[Program Director or Institutional Official]
[Title]
[Organization]
[Address 1]
[Address 2]
[City, State, Zip]

Enclosures: (i) Verification of Graduate Medical Education & Training Form

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:
Click here to enter text.	Click here to enter text.	Click here to enter text.

Program Specialty or Subspecialty:

☐Preliminary Program: Click here to enter text. Date From/To: Click here to enter text.
☐Core Residency Program: Click here to enter text. Date From/To: Click here to enter text.
☐Fellowship Program: Click here to enter text. Date From/To: Click here to enter text.

Training Program Accreditation: ☐ ACGME ☐ AOA ☐Other

If marked "other," please indicate accreditation type or list "none:" Click here to enter text.

Program ID #: Click here to enter text.

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

(If YES, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

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.)*

Click here to enter text.

Section III: Attestation
The information provided on this form is based on review of available training records and evaluations.
Signature: Click here to enter text.
Printed Name: Click here to enter text.
GME Title: Click here to enter text.
Phone Number: Click here to enter text.
Email: Click here to enter text.
Date Form Completed: Click here to enter text.

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.