



### Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.

Program Director or Designated Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of postgraduate training program: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Waiver for Release of Information:** I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Kansas State Board of Healing Arts  
Mailing address: 800 SW Jackson, Lower Level – Suite A  
City/State/Zip: Topeka, KS 66612

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dean or Designated Official:**

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/transitional.

Make copies and attach additional pages if necessary.

Send this form to the Kansas State Board of Healing Arts at the address listed in Section 1 with any added documentation, if applicable.

**Section 2: Postgraduate Training Verification**

Institution name: \_\_\_\_\_

Institution address: \_\_\_\_\_

Institution city / state or province / zip code: \_\_\_\_\_

Affiliated medical school name: \_\_\_\_\_

Institution / school name if different when the applicant attended: \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship

Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

**Applicant Name:** \_\_\_\_\_

Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

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Postgraduate year (e.g., 1, 2, 3, etc.): \_\_\_\_\_  Internship  Residency  Fellowship  
 Research  Chief Residency  Other: \_\_\_\_\_

Specialty/Subspecialty: \_\_\_\_\_

Attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Successfully completed\*?  Yes  No  In progress with expected completion date of \_\_\_\_\_

*\*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by:  ACGME  AOA  LCGME  RSC  CFPC  
 RCPSC  APPAP  None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

**Unusual Circumstances**

- 1. Did this individual ever take a leave of absence or break from his/her training?  Yes  No
- 2. Was this individual ever placed on probation?  Yes  No
- 3. Was this individual ever disciplined or placed under investigation?  Yes  No
- 4. Were any negative reports for behavioral reasons ever filed by instructors?  Yes  No
- 5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason?  Yes  No

**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.**

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)