New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Verification of Postgraduate Training Form

Applicant's name:_____

Hospital: _____

Hospital address: _____
Street City State Zip Code Country

Hospital telephone number: _____
Include area code

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which this physician participated. Provide starting and ending dates of training, type of training and whether credit was awarded.

	Dates (Month/Year)	Specialty	Credit None	Partial	Full
PGY 1					
PGY 2					
PGY 3					
PGY 4					
Fellowship					
Other					

2. Was the residency/fellowship accredited by A.C.G.M.E. or A.O.A.? ☐ Yes ☐ No

3. Was the physician placed on probation, suspended or in any way sanctioned/disciplined or placed under investigation while at your facility? ☐ Yes ☐ No

4. Was the physician granted a leave of absence or break from his/her training? ☐ Yes ☐ No

5. Were any restrictions placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? ☐ Yes ☐ No

6. Were any formal patient or staff complaints filed against this physician? ☐ Yes ☐ No

7. Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? ☐ Yes ☐ No

If you answered "Yes" to any one of questions 3-7, please attach an explanation, and sign and date the attachment. Also, please attach any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

_____ _____
Print Name of Program Director Date

_____
Signature of Program Director

Please return directly to: BMEApp@dca.njoag.gov

Hospital Seal

If the hospital does not have a seal, a letter attesting to this fact, on hospital stationary, must accompany this certificate.