Printed on Letterhead

(Specialty/Subspecialty Residency Name) Program – Confidential Verification and Reference for:

NAME: *(First Name) (MI) (Last Name) (Suffix)*

SOCIAL SECURITY NUMBER: *(Social Security Number)*

This confidential document is provided to you by the (Insert Program Name) Program at Yale-New Haven Medical Center, as a reference for our former resident. We submit this document in response to your request for verification of (Insert specialty/subspecialty name) training and reference information in lieu of other forms. The original signature of the current program director and the residents at the end of this document will verify its authenticity. The letter is also verified by the signature of the present Program Director and notarization of that signature. The contents of this document are provided with the permission of the above named physician and should not be released to any other party without the consent of that physician.

1. **VERIFICATION OF TRAINING:** ***(Name)*** **, MD** successfully trained at (*Insert name of Program)* Program from (*Insert dates of training)*.

2. **COURSE OF TRAINING/CORRECTIVE ACTION:** During the dates of training, Dr. ***(Name)*** was never subject to any disciplinary action, such as admonition, reprimand, suspension, or termination.

3. **PERSONAL INTEGRITY**: To the best of our knowledge, Dr. ***(Name)*** had no signs of behavior, drug, or alcohol problems during residency training.

4. **PROFESSIONAL LIABILITY**: To the best of our knowledge, Dr. ***(Name)*** was not investigated by any governmental or other legal body and was not the defendant in any malpractice suit during residency training.

5. **ABILITY TO PRACTICE MEDICINE**: At the time of training, and to the best of our knowledge, there are no mental or physical conditions that would limit Dr. ***(Name)*** ability to practice medicine.

6. **CLINICAL PRIVILEGES:** The education Dr. ***(Name)*** received from our training program was sufficient for the practice of *(Insert specialty/subspecialty name)*. Dr. ***(Name)*** was recommended for the certifying examination administered by the *(Insert name of appropriate Board).*

7. **PRIVILEGES:** Your list of privileges (if submitted) was reviewed. The training received by Dr. ***(Name)*** was adequate to recommend such privileges except as noted below: (*Insert non-recommended privileges).* I am unable to comment on

requested privileges/procedures outside the scope of a *(Insert specialty/subspecialty name)* residency training program.

8. **EVALUATION:** The following table is based on the demonstrated performance of Dr. ***(Name)*** during residency training, and is compared to the reasonable expected performance of an *(Insert specialty/subspecialty name)* resident.

Superior = 1 ; Average = 2 ; Below Average = 3 ; Poor = 4

Basic Medical Knowledge	2
Professional Judgement	2
Sense of Responsibility	2
Ethical Conduct	2
Competence and Skill	2
Ability to work with others	2
Record Keeping	2
Patient Management	2
Physician-Patient Relationship	2
Appearance	2
History/Physical Examination	2
Case Presentations	2
Relationship with Nursing Staff	2

9. **RECOMMENDATION:** Based on a composite evaluation by the Yale New Haven Medical Center *(Insert name specialty/subspecialty program)* Program's Resident Advisory Committee, ***(Name)*** , MD is recommended to you without reservation. This evaluation is verification that the resident has demonstrated sufficient professional ability to practice competently and independently.

_____ _____
(Name Original Program Director) Date
Program Director

_____ _____
(Name Present Program Director) Date
Program Director

I have reviewed this evaluation with the Program Director or 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 *(insert department/section name).*

Signature (Resident) Date

Resident refused to sign document.

_____ _____
(Name Original Program Director) Date
Program Director

ADDITIONAL COMMENTS :