# 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 Medical Staff Services (NAMSS), and Organization of Program Director 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.

# For 2018 and future graduates:

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.

# For pre-2018 graduates:

The form would be completed **once** – if and when a program receives a request for 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.

***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]

**VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING**

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| **Section I: Verification of training and performance during training****(*To be completed for EACH trainee)*** |
| Trainee’s Full Name:Click here to enter text. | DOB:Click here to enter text. | NPI:Click here to enter text. |
| Program Specialty or Subspecialty:☐Preliminary Program: Click here to enter text. Date From/To: mm/dd/yyyy (Start) – mm/dd/yyyy (End).☐Core Residency Program: Click here to enter text. Date From/To: mm/dd/yyyy (Start) – mm/dd/yyyy (End).☐Fellowship Program: Click here to enter text. Date From/To: mm/dd/yyyy (Start) – mm/dd/yyyy (End). |
| Training Program Accreditation: ☐ ACGME ☐ AOA ☐OtherIf 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 ☐ NoIn 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?1. Conditions or restrictions beyond those generally

associated with the training regimen at your facility; ☐Yes ☐ No1. Involuntary leave of absence; ☐ Yes ☐ No
2. Suspension; ☐ Yes ☐ No
3. Non-promotion/non-renewal; ☐ Yes ☐ No
4. Dismissal; or ☐ Yes ☐ No
5. Resignation. ☐ Yes ☐ No

*(If YES to any of the above, 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.* |

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| **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. |

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| **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.Professional Credentials: 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. |

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