

**Rhode Island Hospital/The Miriam Hospital – Graduate Medical Education
House Officer Training Verification
Revised 1/18/2007; Revised 11/13/2007**

House Officer: _____

1. VERIFICATION: Our records show that the above-named physician served in the following training program at Rhode Island Hospital:

		Completed Program	
		<u>Yes</u>	<u>No</u>
Preliminary Training in _____	from _____ to _____	<input type="checkbox"/>	<input type="checkbox"/>
Residency in _____	from _____ to _____	<input type="checkbox"/>	<input type="checkbox"/>
Fellowship in _____	from _____ to _____	<input type="checkbox"/>	<input type="checkbox"/>

2. EVALUATION: Based on demonstrated performance and composite of evaluations by supervisors on file.

	Competent	Not Competent
Medical knowledge		
Patient Care		
Practice-Based Learning		
Communication and Interpersonal Skills		
Professionalism		
Systems-Based Practice		

2. PROFESSIONAL CONDUCT: These are commonly asked questions on requests for verification. We have answered them to the best of our knowledge for the time he/she spent at Rhode Island Hospital. If our response is yes to any question, please refer to comments section on back for explanation.

	<u>YES</u>	<u>NO</u>
Has the physician been the subject of any professional misconduct action?	<input type="checkbox"/>	<input type="checkbox"/>
Has the physician ever been subject to any corrective or disciplinary action?	<input type="checkbox"/>	<input type="checkbox"/>
Has the physician ever been subject to suspension, termination, or voluntary/involuntary limitation regarding house staff membership or privileges?	<input type="checkbox"/>	<input type="checkbox"/>
Has the physician been a defendant in any professional liability suits in your program?	<input type="checkbox"/>	<input type="checkbox"/>
Has the physician been involved in substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of any facts regarding the physician that cause you to hesitate in any way in recommending membership to the medical staff of any institution?	<input type="checkbox"/>	<input type="checkbox"/>

3. COMMENTS, REMARKS, EXPLANATIONS

House Officer: _____

4. COMPETENCY:

On behalf of the sponsoring institution and the training program, the signatories below verify that the resident has demonstrated sufficient competence to enter practice without direct supervision in the context of the Specialty Training specified.

YES **NO** **N/A***

* Explain N/A as;

- Preliminary Program
- Left program before completing training
- Other _____

SIGNATURE

DATE

NAME (PRINTED/TYPED)

PROGRAM DIRECTOR
TITLE/POSITION

SIGNATURE

DATE

Staci Fischer, M.D.
NAME

DIRECTOR, GRADUATE MEDICAL EDUCATION
TITLE/POSITION