MEDICAL COLLEGE OF WISCONSIN
ANESTHESIOLOGY

RESIDENCY OR FELLOWSHIP TRAINING VERIFICATION REQUEST

STEP I – Requesting Organization

Please fill in the name, address, phone and fax numbers of the organization and person making this request:

Requesting individual's name: _____
Organization name: _____
Address: _____
_____
Phone/fax numbers: _____

STEP II – Requesting Verification for What Individual

Please complete all fields:

Name of the individual: _____
Name of program completed: _____
Years of training in requested program: _____
If more than one program, please list additional programs and training years:
_____

STEP III – Payment Options

☐ Check ☐ Visa ☐ MasterCard

Name on card: _____

Account number: _____

Expiration Date: _____ CVC: _____

Signature*: _____

*By signing I understand that I am authorizing the charge of:

☐ $25 for a standard verification (only successfully completed and dates of training) OR

☐ $75 for a detailed verification (attach your verification form)

Forms can be emailed unless paying by check; please mail checks along with this form to: Medical College of Wisconsin, Department of Anesthesiology, Education Division – Pavilion Bldg. 3rd Floor, ATTN: Administrative Assistant, 9200 West Wisconsin Avenue, Milwaukee, WI 53226

Remember to attach:

1.) Release Authorization
2.) Your Own Verification Form (if needed)