Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

CERTIFICATE OF POST-GRADUATE TRAINING

(Not necessary if utilizing FCVS)

APPLICANT: **Please forward this form to your post-graduate training program(s) for completion.**

TRAINING PROGRAM: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant/Physician's Name:	
Hospital/Program Name:	
Hospital/Program Address:	
Hospital/Program's Daytime Phone:	___ - ___ - ____

1. In what type and level(s) of training did this Physician participate at your facility? Indicate below each level of training in which the above named Physician participated in your program. Provide start/end dates, type of training, and whether credit was given for the training.

DATES OF TRAINING(month/day/year)	**TYPE OF SPECIALTY TRAINING**	**FULL CREDIT**	**PARTIAL CREDIT**
PGY 1: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
PGY 2: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
PGY 3: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
PGY 4: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
Fellowship: __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐
Transitional (Other): __/__/__ to __/__/__		Yes ☐ No ☐	Yes ☐ No ☐

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		YES	NO
2.	Was the internship/residency/fellowship in the United States or Canada accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC), or the College of Family Physicians of Canada (CFPC)?	☐	☐
3.	Did the Physician either complete the training program in good standing, or is the Physician currently in the training program and in good standing? **If no, please attach explanation on a separate sheet**.	☐	☐
4.	Was this Physician recommended for the Board Certification Examination in this specialty?	☐	☐

If you answer Yes to questions 5-14, attach an explanation on a separate sheet.

5.	Was the Physician asked, or required, to repeat any portion of the training program?	☐	☐
6.	Was the Physician placed on probation, suspended, or in any way sanctioned or disciplined while in the program? **If yes, please indicate if this constitutes an adverse formal action.**	☐	☐
7.	Was this Physician granted a leave of absence while in the training program?	☐	☐
8.	Did this individual have a record of unexcused absences during his/her attendance in this training program?	☐	☐
9.	Were any restrictions and/or special requirements placed on this Physician's activities that were not placed on all other residents/fellows at his/her level of training?	☐	☐
10.	Were any formal patient or staff complaints filed against this Physician?	☐	☐
11.	Were any incident reports filed involving the professional behavior or conduct of this Physician?	☐	☐
12.	Was this Physician ever subject to non-routine monitoring while in the training program?	☐	☐
13.	Were any malpractice actions filed naming this Physician as a defendant that involved his/her period of training in the program?	☐	☐
14.	Is there any additional information in this Physician's file that would assist the Board in determining this applicant's eligibility for licensure?	☐	☐

FOR PHYSICIANS CURRENTLY COMPLETING PGY 2 YEAR:

15.	Has the Physician completed and received credit for 12 consecutive months of training program and is expected to continue in the program and complete at least 24 months of post-graduate training?	☐	☐

If yes, please indicate the expected completion date of the 24 months of training: ___/___/___

Printed Name of Program Director: _____

Signature of Program Director: _____ Date ___/___/___

Post-graduate Training Program, please return directly to:

DSPS
Attn: Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Alternatively, you may fax/email with facility cover sheet/letter to: (608) 261-7083 or DSPSCredMedBD@wisconsin.gov.