

DEPARTMENT OF NEUROSURGERY



Residency or Fellowship Training Verification Request Form

Step 1: Requesting Organization

Please fill in the name, address, phone number and e-mail of the organization and person making this request.

Name: _____

Organization Name: _____

Address: _____

Phone Number: _____

E-mail Address: _____

Step 2: Requesting Verification for what Individual

Please complete all of the fields below.

Name of Individual: _____

Name of Program Completed: _____

Years of training in Requested Program: _____

If more than one program, please list additional programs and training years.

Step 3: Payment

Select which authorization form you'd like and e-mail to the contact below. Once form is received, we will send you a PayPal link to pay for the authorization. Once payment is confirmed we will complete the authorization form. Payment is charged for each verification requested.

_____ \$50 for each standard verification (only successfully completed and dates of training)

OR

_____ \$100 for each detailed verification (attach your verification form to the e-mail)

E-mail the complete form to Orlando Diaz at odiaz@mcw.edu