Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226
ahicks@mcw.edu

Training Verification: BASIC

SECTION I: GENERAL INFORMATION

NAME OF APPLICANT: _____

INSTITUTION WHERE PROGRAM WAS SERVED: **Medical College of Wisconsin**

TYPE/SPECIALTY OF TRAINING PROGRAM:

1. DATES PROGRAM SERVED. **From:** ___/___/___ **TO:** ___/___/___.	Yes**	No
2. Is this program ACGME Accredited?		
2b. If "NO", please give name of accrediting body in full:		
3. Was the training program completed?		
3b. If the answer is "NO", please explain in the area below.		
4. Were there any sanctions or other disciplinary action taken against this applicant during this time?		
5. To your knowledge has the practitioner ever been under investigation by any governmental or other legal body?		
6. Was the practitioner ever subject to any malpractice action?		
** If "Yes" to any of the above, excluding question 3, please explain in the area below.		

Question #(s): _____ Explanation(s): _____

_____

_____

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SECTION II: CONTACT INFORMATION

Email/Phone:	Best time to contact you:
Program Coordinator Printed Name:	
SIGNATURE:	DATE: