

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 the Program completed: _____

Years of training in Requested Program: _____

If More than one Program, please list additional programs and training years: _____

Step III – Payment

Check

Please mail *checks* along with this form to:

Medical College of Wisconsin
Department of Radiology Education Division
9200 W Wisconsin Avenue,
Milwaukee, WI 53226
Attn: Abigail Goelzer

Remember to attach:

- 1) Release Authorization
- 2) Your own Verification Form (if needed)

Updated: August 11, 2022