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: Amanda Hicks

Remember to attach:

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

Updated: December 12th, 2024