Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226
mezimmermann@mcw.edu
414-955-1195

Training Verification: **BASIC PLUS**

SECTION I: GENERAL INFORMATION

Name of practitioner:		
Name of program institution: **Medical College of Wisconsin**		
Name of training specialty:		
Program Dates **Start:** **End:**		
Did the practitioner complete the training of this program? Please Explain.	Yes	No
Is this program ACGME Accredited?	Yes	No
If 'NO', please name the educational institution in full:		
Were there any sanctions or other disciplinary action taken against this applicant during this time? Please Explain.	Yes	No
To your knowledge has the practitioner ever been under investigation by any governmental or other legal body? Please Explain.	Yes	No
Was the practitioner ever subject to any malpractice action? Please Explain.	Yes	No

Explanation(s): ____

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SECTION II: CONTACT INFORMATION

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

 Last Modified: August 15, 2019