



Medical College of Wisconsin
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Training Verification: COMPREHENSIVE – ACADEMIC SEAL REQUIRED

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): _____

SECTION II: EVALUATION of Practitioner in General Competencies:

Area of Competency	Meets Expectations	Needs Improvement**	Unable to Assess**
1. Medical / Clinical Knowledge in Specialty			
2. Clinical Judgment			
3. Technical and Clinical Skills			
4. Quality / Medical Record Completion			
5. Ability to Understand, Speak, and Write English			
6. Physician-Patient Relationship			
7. Patient Management			
8. Participation in Medical Staff Affairs			
9. Sense of Responsibility			
10. Ethical Conduct: clinical care, patient confidentiality, informed consent, and business practice.			
11. Cooperativeness, Ability to Work with Others (e.g. peers, nurses, administrative staff)			
12. Analyze practice experience, evaluate outcomes & makes appropriate changes			
13. Practice cost-effective healthcare & resource allocation that does not compromise quality of care			

** Please explain the reason for your evaluation to assess in the space below.
Attach a separate sheet if necessary.

My evaluation is based on:

General & Personal Observation_____ File Records_____ Composite of Evaluation(s)_____

Competency #(s): _____ Explanation(s): _____

SECTION III: RECOMMENDATION

- A. How many years have you known the practitioner? _____
- B. What is/was your relationship to the practitioner? _____

Practitioner is (please select option A, B, or C):

- ____ A. Recommended without reservation.
- ____ B. Recommended with the following reservations (please explain):

- ____ C. CANNOT RECOMMEND (Please explain in detail):

Section IV: Certification

Affix your institutional seal in this space.
If no institutional seal exists, this form
must be notarized.



SECTION V: CONTACT INFORMATION

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

TITLE: Program Director _____
Associate Program Director _____
or
Other: _____

Please explain history in or associated with position:

