Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226
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Training Verification: COMPREHENSIVE – ACADEMIC SEAL REQUIRED

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): _____

_____

_____

_____

_____

SECTION II: EVALUATION of Applicant 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 applicant? _____

B. What is/was your relationship to the applicant? _____

Applicant 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:

_____

_____