Form #3

State of Nevada - Board of Osteopathic Medicine
Graduate Medical Education

(Copy this form for multiple residency programs)

Applicant Instructions: Complete Section 1 and Section 2 of this form then send this form to **each and every residency program or fellowship you attended**. Request the Chief of Medical Staff or designated official to complete Section 3 of this form and return to this Board.

Section 1: Applicant Information

Last Name:_____ First Name:_____ Middle Name:_____

Name if different when diploma awarded:_____

Social Security Number:_____ Date of Birth:_____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

Waiver for release of information: I authorize this hospital or medical center listed below to provide any and all information pertaining to my medical staff privileges at your institution to the State of Nevada - Board of Osteopathic Medicine.

_____ _____
Applicant's Signature Date

PGY: _____ (e.g., 1, 2, 3, etc.) ☐ Internship ☐Residency ☐Fellowship ☐Research

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Section 3: RESIDENCY or FELLOWSHIP VERIFICATION

Institution Name:_____

Institution Address: _____
Street City State Zip Code

Affiliated Medical School Name:_____

Type of Specialty:_____

Training Period From Date: _____/_____/_____ To Date: _____/_____/_____

Current Status of Residency: _____

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Unusual Circumstances:

Did this individual ever take a leave of absence or break from his/her residency?	☐Yes	☐No
Was this individual ever placed on probation or suspension?	☐Yes	☐No
Was this individual ever disciplined or placed under investigation?	☐Yes	☐No
Were any negative reports for behavior reasons ever filed by instructors?	☐Yes	☐No
Were any limitations or special requirements imposed because of academic performance, incompetence, disciplinary problems or any other reason?	☐Yes	☐No

Please explain any "Yes" response from above (attach additional pages if necessary):_____

_____

_____

_____

_____

_____

I certify that to the best of my knowledge and belief the foregoing is a true, accurate and complete statement of the record of the individual named on this form.

Signature:_____

Print name:_____

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized)

Title:_____

Date:_____

Phone number:_____ Fax:_____

E-mail: _____

Return to:

State of Nevada - Board of Osteopathic Medicine
2275 Corporate Circle, Suite 210
Henderson, NV 89074
702-732-2147
702-732-2079 (fax)
Toll Free: (877) 325-7828