Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226

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: /

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: