Medical College of Wisconsin
9200 W Wisconsin Ave
Milwaukee WI, 53226
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Training Verification COMPREHENSIVE

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?		
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3.

SECTION II: EVALUATION of Applicant in General Competencies

Area of Competency	Meets	Needs	Unable to
1. Medical/ Clinical Knowledge in Specialty			

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: CONTACT INFORMATION

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