Initial Application – Supportive Verification Form

The purpose of this form is to verify the applicant's criteria for certification. This document must be included with the application.

Name of Applicant: _____ Name of Supporter: _____

Professional relationship to the applicant (please check one):

□ Program Director
□ Assistant or Associate Program Director
□ Director of Medical Education
□ Designated Institutional Official
□ Department Chair

Please verify the following:

Initials_____ 1. The applicant has been an administrator, GME Coordinator or DIO for this training program or institution for at least 2 years or more.

OR Initials ____ 2. **OR** a letter is attached from the former program stating dates of employment, job title/duties and verification in which your name was listed at ACMGE.org as the Program Coordinator contact for that residency, fellowship or institution.

Initials_____ 3. The applicant has sufficient skills, knowledge and abilities to manage the day-to-day responsibilities and activities of the training program.

Additional Comments

_____ _____

Signature Date

(Only original signatures accepted please.)