

**North Dakota Board of Medicine
Postgraduate Training Form**

TO APPLICANT: The North Dakota Board of Medicine requires letters from each of your postgraduate training programs. This form must be completed by the current program director and mailed **directly** to the Board at **4204 Boulder Ridge Rd, Ste 260, Bismarck, ND 58503-6162**. The completed form may also be **faxed to 701-989-6392** but **MUST** be sent with a fax cover sheet that provides the Board with the required primary source verification. The form may also be emailed to license@ndbom.org
In addition, the reference forms must meet the following criteria:

- a) Currently dated
- b) Contain an original signature
- c) Be completed in full

Please be sure to indicate the applicant's name below for identification purposes.

Applicant Name: _____
(First name) (MI) (Last name) (Date of Birth)

Program Name: _____

(Address) (City) (State) (Zip)

Program Specialty Type: _____
Specialty/Type of Program (i.e. General Surgery Residency)

Dates of training from: _____ **Date of successfully completed:** _____
Month/Day/Year Month/Day/Year

Was this training program accredited by the Accreditation Council for Graduate Medical Education (ACGME); American Osteopathic Association (AOA); or the Royal College of Physicians & Surgeons of Canada (RCPSC)? YES ____ NO ____

THE FOLLOWING QUESTIONS MUST BE ANSWERED:

1) Please indicate the quality of his/her work **OR** state why this information cannot be provided:

2) Please indicate ANY derogatory information **OR** state why this information cannot be provided:

Print Name

Date

Program Director Signature

Email Address

Phone #: