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. 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 **Phone Number**

_____ _____
Program Director Signature **Email Address**

Date Signed: _____