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 be sent **directly** to the Board by: mail at **4204 Boulder Ridge Rd, Ste 260, Bismarck, ND 58503-6162,** email to license@ndbom.org, or f**axed to 701-989-6392** with a fax cover sheet that provides the Board with the required primary source verification.

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

Program Name: _____

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

Program: _____
Specialty and Type of Program (i.e. General Surgery Residency, Pediatrics Fellowship, etc.)

Dates of training from: _____ **Date of successful completion:** _____
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 QUESTION MUST BE ANSWERED:

Please indicate quality of work or any derogatory information OR state why this information is not being provided:

_____

_____

_____ _____
Print Name **Phone Number**

_____ _____
Program Director Signature **Email Address**

Date Signed: _____