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: _____ DOB:_____
(First name) (MI) (Last name) (Date of Birth)

Program Name: _____

Program Address: _____
(Street) (City) (State) (Zip)

Program: _____
Specialty and Type of Program (i.e. General Surgery Residencey, Pediatric Fellowship)

Training Dates from: _____ **Completion Date**: _____
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: _____