**Residency Verification**

(provided by Ohio State University/Nationwide Children’s Hospital; 2017)

**INSTITUTION(S) NAME**

**COMBINED INTERNAL MEDICINE-PEDIATRIC RESIDENCY PROGRAM**

***CONFIDENTIAL VERIFICATION AND REFERENCE FOR:***

|  |  |
| --- | --- |
| Name: |  |
| NPI Number: |  |
|  |  |  |  |  |
| This confidential document relating to a former resident is provided to you by THE INSTITUTION Combined Internal Medicine-Pediatric Residency Program. We submit this document and reference in response to your request for verification of training in Internal Medicine and Pediatrics in lieu of other forms.  **Please note, this form verifies both the Internal Medicine and Pediatrics components of this physician’s residency training in the Combined Internal Medicine-Pediatric program.**  The original notarized signature of the current program director will verify its authenticity. The contents of this document are provided with the permission of the above named physician, and should not be released to any other party without the consent of that physician. |
|  |  |  |  |  |
| **I.** | **Verification of Training** |  |  |  |
|  | **Dr.** successfully completed the Internal Medicine and Pediatrics residency training at The Ohio State University Wexner Medical Center and Nationwide Children’s Hospital as follows: |
|  |  | Internship: |  |  |
|  |  | Residency: |  |  |
|  | ❑ | See Appendix I |  |  |
|  |  |  |  |  |
| **II.** | **Disciplinary Action** |  |  |  |
|  | ❑ | During the dates of training at this institution, **Dr.** was not subject to any disciplinary action. |
|  |  |  |
|  | ❑ | See Appendix II |
|  |  |  |
| **III.** | **Professional Liability** |
|  | ❑ | To the best of our knowledge, **Dr.** was not investigated by any governmental or other legal body and was not the defendant in any malpractice suit during residency training. |
|  |  |  |
|  | ❑ | See Appendix III |
|  |  |  |
| **IV.** | **Ability to Practice Medicine** |
|  | ❑ | To the best of our knowledge, no conditions exist that would impair **Dr. ‘s** ability to practice Internal Medicine and Pediatrics without direct supervision. |
|  |  |  |
|  | ❑ | See Appendix IV |
|  |  |  |
| **V.** | **Clinical Privileges/Procedures Requested** |
|  | ❑ | The education **Dr.** received from our training program is sufficient for the practice of General Internal Medicine and General Pediatrics. **He/She** was recommended for the certifying examination administered by the American Board of Internal Medicine and the American Board of Pediatrics. |
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| **V.** | **Clinical Privileges/Procedures Requested (continued)** |
|  | ❑ | At the conclusion of **Dr.’s** Combined Internal Medicine-Pediatrics residency training **he/she** was judged capable of performing the following procedures independently: |
|  |  |  | **General Medicine Procedures** |  |  | **General Pediatrics Procedures** |
|  |  | ❑ | Advanced cardiac life support |  | ❑ | Lumbar puncture |
|  |  | ❑ | Arthrocentesis of the knee |  | ❑ | Wound care and suturing of lacerations |
|  |  | ❑ | Lumbar puncture |  | ❑ | Endotracheal intubation |
|  |  | ❑ | Abdominal paracentesis |  | ❑ | Thoracentesis/Chest tube placement |
|  |  | ❑ | Interpretation of electrocardiograms |  | ❑ | Arterial puncture |
|  |  | ❑ | Insertion of subclavian central line |  | ❑ | Venipuncture |
|  |  | ❑ | Insertion of femoral central line |  | ❑ | Umbilical artery and vein catheter placement |
|  |  | ❑ | Insertion of internal jugular central line |  | ❑ | Placement of interosseous/intravenous lines |
|  |  | ❑ | Insertion of arterial line |  | ❑ | Bladder catheterization/suprapubic tap |
|  |  | ❑ | Arterial puncture |  | ❑ | Gynecologic evaluation |
|  |  | ❑ | Flexible sigmoidoscopy |  | ❑ | Injections |
|  |  | ❑ | Bone marrow aspiration and biopsy |  | ❑ | Developmental screening test |
|  |  | ❑ | Insertion of Swan Ganz catheter |  | ❑ | Incision and drainage of abscesses |
|  |  | ❑ | Punch skin biopsy |  | ❑ | Conscious sedation |
|  |  | ❑ | Thoracentesis |  | ❑ | Circumcision |
|  |  | ❑ | Nasogastric intubation |  | ❑ | Foreign body removal |
|  |  | ❑ | PAP smear and endocervical culture |  | ❑ | Reduction and splinting of simple dislocations |
|  |  | ❑ | Other |  | ❑ | Pediatric Advanced Life Support |
|  |  |  |  |  | ❑ | Neonatal resuscitation |
|  | ❑ | I am unable to comment on requested clinical privileges/procedures outside the scope of a General Internal Medicine/General Pediatrics residency training program. |
|  |  |  |
| **VI.** | **Evaluation** |
|  | The following is derived from a composite of multiple evaluations by supervisors in this resident’s rotations during his/her residency training. The evaluation is based upon the Accreditation Council for Graduate Medical Education (ACGME) General Competencies, which define the essential components of clinical competence. In cases where the definition of the competency could be unclear, the ACGME definition is given after the table. |
|  |  |
| ***Internal Medicine Component*** | **Unsatisfactory** | **Satisfactory** | **Superior** | **No Knowledge** |
| Medical Knowledge |  |  |  |  |
| Patient Care |  |  |  |  |
|  | Interviewing |  |  |  |  |
|  | Physical Examination |  |  |  |  |
|  | Procedures |  |  |  |  |
| Professionalism |  |  |  |  |
| Communication and Interpersonal Skills |  |  |  |  |
| Practice Based Learning and Improvement\* |  |  |  |  |
| Systems Based Practice\*\* |  |  |  |  |
| *\*Residents receiving a satisfactory evaluation in Practice Based Learning perform satisfactory investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.* |
| *\*\*Residents receiving satisfactory evaluation in Systems Based Practice demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.* |
|  |
| **VI.** | **Evaluation (continued)** |
| ***Pediatric Component*** | **Unsatisfactory** | **Satisfactory** | **Superior** | **No Knowledge** |
| Medical Knowledge |  |  |  |  |
| Patient Care |  |  |  |  |
|  | Interviewing |  |  |  |  |
|  | Physical Examination |  |  |  |  |
|  | Procedures |  |  |  |  |
| Professionalism |  |  |  |  |
| Communication and Interpersonal Skills |  |  |  |  |
| Practice Based Learning and Improvement\* |  |  |  |  |
| Systems Based Practice\*\* |  |  |  |  |
| *\*Residents receiving a satisfactory evaluation in Practice Based Learning perform satisfactory investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.* |
| *\*\*Residents receiving satisfactory evaluation in Systems Based Practice demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.* |
| **VII.** | **Comments** |
|  |  |
| **VIII.** | **Recommendation** |
|  | Based on a composite evaluation by DEPARTMENTS OF IM AND PEDS, **Dr.** is recommended to you this **30th day of June, 20\_\_.** |
|  |  |  |
|  |  | PROGRAM DIRECTOR, MD |
|  |  | Internal Medicine-Pediatric Residency Program Director |
|  |  |  |
| **IX.** | ❑ | I have reviewed this evaluation with the program director. I understand that this form will, in most cases, be utilized as the confidential verification and reference form in lieu of other forms when requests for verification of resident training and/or reference are received by the Department of Medicine and Department of Pediatrics. |
|  |  |  |
|  |  | **RESIDENT, MD** |
| **X.** | ❑ | Resident reviewed the evaluation, but chose not to sign. |
|  |  |  |
|  |  | PD, MD |
|  |  |  |
| **XI.** | ❑ | Resident did not review the evaluation. |  |
|  |  | PD, MD |
|  |
| ***“I attest that the foregoing information supplied is true in every respect.”*** |
|  |  |  |  |
|  | PD, MD |  | Date |
|  | State of  | County of | PROGRAM ADDRESSPHONE |
|  | Subscribed and sworn before me on this day: |
| *NOTARY SEAL* |  |
| Date |
| Notary Signature |
|  | Notary Name (Typed or Printed) |  |
|  | My Commission Expires on |  |