

Augusta University
House Staff Policies and Procedures

Policy
HS 11.0 Graduation Verification

Source
Graduate Medical Education Office

ATTACHMENT A

PLACE ON DEPARTMENT LETTERHEAD

RELEASE OF INFORMATION FORM

I hereby authorize _____ (Name of Medical School(s)) to release any and all information requested by Augusta University in order for them to verify my professional competence, ethics, character, academic record, and other qualifications for a House Staff appointment. In doing so, I hereby waive any rights of confidentiality in these records, including those granted by the Family Education Rights and Privacy Act, and I release and hold harmless anyone making good faith use of such information in accordance with this release.

Name of Training Program

Print/Type Name (First, Middle, Last Name, Jr./Sr., etc.)

Social Security Number

Signature

Date

Effective Date:
7/05

Revision/Review Date:
12/05, 10/07, 12/09, 10/10, 2/11
1/13, 10/14, 9/15, 1/16, 2/17, 6/19, 8/22, 2/23

Number:
HS 11.0

2

Augusta University
House Staff Policies and Procedures

Policy
HS 11.0 Graduation Verification

Source
Graduate Medical Education Office

ATTACHMENT B

PLACE ON DEPARTMENT LETTERHEAD

Letter to Registrar

Date

Registrar's Office
(Address)

RE: House Staff's Name
 Social Security Number

To whom it may concern:

The above referenced applicant is applying for appointment to Augusta University (name of GME Training Program). The applicant has indicated that they are a graduate of your Medical School.

In order to complete this application, I must verify that this information is accurate. Please respond to the included Medical School Graduation Verification Form and return your response in the enclosed self addressed envelope. A release of information form has been provided by the applicant and is also enclosed. Your prompt response by (date 30 days from the date of the letter) will be appreciated.

Sincerely,

(Training Program Coordinator)
(Department/Service)
Augusta University
1459 Laney Walker Blvd
Augusta, GA 30912

Enclosures: Release Form
 Medical School Graduation Verification Form
 Self-Addressed Envelope

Effective Date:	Revision/Review Date:	Number:	3
7/05	12/05, 10/07,12/09,10/10,2/11 1/13, 10/14,9/15,1/16, 2/17, 6/19, 8/22, 2/23	HS 11.0	

Augusta University
House Staff Policies and Procedures

Policy
HS 11.0 Graduation Verification

Source
Graduate Medical Education Office

ATTACHMENT C

PLACE ON DEPARTMENT LETTERHEAD

Medical School Graduation Verification Form

First Name	Middle Name	Last Name	(Jr/Sr., etc.)
------------	-------------	-----------	----------------

Social Security Number

Has successfully completed requirements and has graduated from the _____
Name of Medical School

Located in _____
City State Country

Date of Graduation: _____
Month Day Year

Additional Comments: _____

Signature: _____

Typed/Printed Names: _____

Title: _____

Augusta University
House Staff Policies and Procedures

Policy
HS 11.0 Graduation Verification

Source
Graduate Medical Education Office

ATTACHMENT D

<http://www.ecfm.org/cvs/requesting-status-report.html>