

Augusta University
House Staff Policies and Procedures

Policy
HS 11.0 Graduation Verification

Source
Graduate Medical Education Office

1.0 Purpose

To establish guidelines for ensuring that House Officers provide verification of graduation

2.0 Procedure

2.1 Release of Information Form

When an applicant is interviewed for a House Officer position at Augusta University, the attached Release of Information Form (Attachment A) must be completed and placed in the applicant's folder.

2.2 Verification – Medical School Graduation Verification

Once an applicant is selected for a House Officer position, medical school graduation verification can begin as follows:

2.2.1 Medical Graduates – United States, Canada and Puerto Rico

The following must be sent directly to the medical school from which the M.D., MBBS, MBBS Ch, or D.O. degree was received.

- Release of Information form (see 2.1 above) – Attachment A
- Letter to Registrar- Attachment B
- Medical School Graduation Verification Form – Attachment C
- Self-Addressed Return Envelope

Note: Graduates of medical schools in Puerto Rico and Canada are not considered international medical graduates (IMG). Therefore, medical school graduation verification should be processed the same as graduates from medical schools in the United State.

Within 45 days from the start date of the Training Program, the completed Medical School graduation Verification Form or Request for Status Report of ECFMG Certification must be on file in the department House Officers folder. A contract will not be issued until a notarized medical diploma is filed in the GME Office.

2.2.2 International Medical graduates (IMG)

The Educational Commission for Foreign Medical Graduates (ECFMG) certified physicians have their medical education credentials verified by the ECFMG. An ECFMG Certification must be valid through the start date of the Training Program and must be on file with the House Officers application before a contract will be issued.

The attached Request for Status Report of ECFMG Certification (Attachment D) should be completed by the Program Director and sent to ECFMG if the House Officer does not have a certification. According to the ECFMG, the completed request should be returned to the Program Director within 2 weeks or less.

Within 45 days from the start date of the Training Program, the completed Medical School Graduation Verification Form or Request for Status Report of ECFMG Certification must be on file in the department House Officers folder. A contract will not be issues until a notarized medical diploma is filed in the GME Office.

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2.2.3 Fifth Pathway Medical Graduates

Medical verification of graduates from Fifth Pathway Programs must provide the Program Director with the following:

- A copy of the Fifth Pathway Certificate and the name/address of the medical school from which the certificate was received

The following must be sent directly to the medical school from which the medical degree was received:

- Release of Information Form (see 2.1 above) – Attachment A
- Letter to Registrar – Attachment B
- Medical School Graduation Verification form – Attachment C

2.3 Medical School Graduation Verification Form or the Request for Status Report of ECFMG Certification.

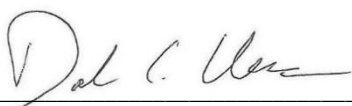
Within 45 days from the start date of the Training Program, the completed Medical School Graduate Verification Form or Request for Status Report of ECFMG Certification must be on file in the department House Officers' folder.

2.4 All intern, residents, and fellows must have a notarized copy of their medical diploma on file in the Graduate Medical Education Office before a contract will be issued.

2.5 Attachments


Attachments

ATTACHMENT A - Release of Information Form
ATTACHMENT B – Letter to Registrar
ATTACHMENT C- Medical School Graduation Verification Form
ATTACHMENT D- Request for Status Report of ECFMG Certification



David Hess, M.D.
Dean, Medical College of Georgia

7/21/21
Date



Natasha M. Savage, M.D.
Interim Associate Dean, Graduate Medical Education and DIO

7/1/21
Date

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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 Office 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

Number:
HS 11.0

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ATTACHMENT B

PLACE ON DEPARTMENT LETTERHEAD

Date

Registrar's Office
(Address)

RE: House Officers Name
 Social Security Number

Dear Sir/Madam:

The above referenced applicant is applying for appointment to Augusta University (name of Residency or Fellowship Program). The applicant has indicated that he/she is 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 questionnaire 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:	4
7/05	12/05,10/07,12/09,10/10,2/11 1/13,10/14,9/15,1/16, 2/17, 6/19	HS 11.0	

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ATTACHMENT C

PLACE ON DEPARTMENT LETTERHEAD

Medical School Graduation Verification Form

First Name	Middle Name	Last Name	(Jr/Sr. ect)
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Social Security Number

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

Located in _____
City State Country

Date of Graduation: _____
Month Day Year

Additional Comments: _____

Signature: _____

Typed/Printed Names: _____

Title: _____

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ATTACHMENT D

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