FCVS RELEASE FORM

For you to obtain initial licensure in the state, the Louisiana State Board of Medical Examiners (LSBME) uses a service of the Federation of State Medical Boards (FSMB) called Federation Credentials Verification Service (FCVS). As you move to full licensure, the LSBME will use reports from FCVS. To have the information to prepare those reports, FCVS requires us to update their files each year on your progress by filling out the below form which is the same one filled out for initial licensure. By copy of this release you consent to allow us to release all of the below requested information to FCVS on an annual basis during your training including a summary report if requested by FCVS. For those not pursuing full licensure, we will still prepare and submit these same reports to FCVS. A benefit to you is that throughout your practice years as you switch hospitals and health plans your training information will be available through FCVS which will significantly speed your credentialing process. This release is valid for activities occurring during your training program.

Resident name: (print)________________________Program Name:______________________________

Resident signature: _________________________________Date:______________________________

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Sample FCVS Verification

Verification of Postgraduate Medical Education

Institution: ____________________
Address: ____________________
____

Attention: **Program Director**
Affiliated University: ____________________

Verification For:
Name: ____________________
SSN: ____________________
DOB: ____________________
Individual's Name on Record (If different from above): ____________________

Program Participation:
Important:
Report Incomplete postgraduate years (PGY) separate from those that were successfully completed.
If the postgraduate year is currently in progress report the expected completion date in the "To" field.
Report Internships, Residencies and Fellowships separately.
Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: ___ ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: ____________________
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

PGY: ___ ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: ____________________
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

PGY: ___ ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: ____________________
From: __________ **To:** __________
Successfully Completed?: Yes ☐ No ☐ In Progress ☐
Accredited by: ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ FMRAC ☐ None of these ☐

Unusual Circumstances:
Check the correct response. Omitted responses require written explanation.
If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from the training? ☐Yes ☐No
2. Was this individual ever placed on probation? ☐Yes ☐No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☐No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☐No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☐No

Please explain any "Yes" response from above: (attach an additional sheet if necessary)

Certification:
Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section must be signed by the Program Director (M.D./D.O. only), or if appropriate, the Director of GME.

Name: ____________ Signature: ____________
Title: ____________ **Date of Signature:** ____________
Tel: ____________ **Fax:** ____________ **E-Mail:** ____________

Rev. 09/07/05 Packet ID: ____________ Request ID: ____________ ____________

Rev2/11