

National Capital Consortium Graduate Medical Education Release and Authorization

Name (Last, First, Middle) Degree: MD/DO/Other (please specify)

Service Branch Hospital of Training

Name Trained Under (if different from above)
If you had a name change since training, please provide documentation reflecting your current legal name such as, Marriage, Divorce or Legal Name Change (court paperwork)

Date of Birth Last 4 digits of SSN or NPI #

I request verification of my training conducted at the National Capital Consortium in the following program(s):

Type of Training	NCC Program (Specialty)	Dates of Training (From – To)	Successfully Completed (Y or N)
Internship			
Residency			
Fellowship			

I hereby release the NCC and their representatives from any and all claims, demands or liability whatsoever relating to or arising out of either the disclosure of such information or the use of such information.

Signature: _____

Date: _____

Please send verification information to:

Organization Name: _____

Mailing Address (No PO Box): _____

Contact Person: _____

Email: _____ Phone # _____

If applying for a California State License, please provide:

Application # _____ File # _____