Natonal 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)

_____ _____ or _____
Date of Birth Last 4 digits of SSN 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 # _____