

**DEPARTMENT OF VETERANS AFFAIRS**

**Southeast Louisiana Veterans Health Care System**

**P.O. Box 61011**

**New Orleans LA 70161-1011**

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|  | In Reply Refer To: 629/002C AY2014-2015 |
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**TRAINEE QUALIFICATION AND CREDENTIALS VERIFICATION LETTER**

**ACADEMIC YEAR 2014-2015**

Date>

Julie Catellier

Director (00)

Southeast Louisiana Veterans Health Care System

P.O. Box 61011

New Orleans, LA 70161-1011

Dear Ms. Catellier:

 I certify that the information identified on the enclosure of this letter has been verified for the trainees listed therein, who are scheduled to receive all or part of their clinical training at the Southeast Louisiana Veterans Health Care System (SLVHCS) New Orleans, LA.

 In addition, I certify that these trainees:

 a. are accepted for participation in the designated VA training program and have met criteria for the specified level of training;

 b. have satisfactory health to perform the duties of the clinical training program;

 c. have had tuberculin testing as required by the Center for Disease Control (CDC) and VA standards;

 d. have had Hepatitis B vaccination or have signed declination waivers;

 e. have completed mask fit testing as required by SLVHCS Safety Department;

 f. have had primary source verification of educational credentials as required by the VA sponsored training program;

 g. have had primary source verification of current licenses, registrations, including DEA registration, or certifications through the State Licensing Boards and/or National and State Certification bodies as required by the VA sponsored training program;

 h. have had primary source verification of the ECFMG (Educational Council for Foreign Medical Graduates) certificates as appropriate;

 i. have provided letters of reference as required by the VA sponsored training program;

 j. have been screened against the Health and Human Services’ Health Integrity and Protection Databank (HIPDB) as appropriate for licensed trainees; and

 k. have been screened against the Health and Human Services’ List of Excluded Individuals and Entities (LEIE) for all trainees.

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Ms. Catellier

 I will notify the SLVHCS Designated Education Officer within 72 hours of changes in the academic status of individual trainees, adverse actions that affect the trainees’ appointment, or changes in health status that pose a risk to the safety of trainees, other employees, or patients.

 I understand that separate documents verifying that the trainees listed on the enclosure to this TQCVL have received tuberculin testing, mask fit testing, and Hepatitis B vaccinations will be provided to the SLVHCS Graduate Medical Education Office as soon as possible ***prior*** to the beginning of Academic Year 2014-2015.

 I certify that all documents pertaining to the listed trainees are maintained on file and available to authorized SLVHCS officials for review.

 Sincerely yours,

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (*signature*)

 >typed name of Program Director

 >typed title

 >typed name of program

Acting Designated Education Officer, SLVHCS

Accept/Do Not Accept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief of Staff, SLVHCS

Accept/Do Not Accept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director, SLVHCS

Accept/Do Not Accept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enclosure: List of credentialed graduate medical education trainees

***NOTE:***  *Any trainee who does not meet all of the criteria or upon whom all primary source verification has not been completed should be processed on a* ***separate*** *TQCVL. For these trainees, deficiencies or discrepancies should be stated explicitly and an explanation provided.*

Academic Year: **2014-2015**

### > title of program, centered here

 SSN (last Discipline of study Degree Level

 Trainees Name 4 numbers) or Specialty or PGY (post graduate year)

The information you provide on any individual named above will be

disclosed to the individual upon his or her request.