

# 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, which is required to enter the 3<sup>rd</sup> year for US graduates, the LSBME will again 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. 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 the duration of your training program unless you instruct otherwise in writing.

Resident name: (print) \_\_\_\_\_ Program Name: \_\_\_\_\_

Resident signature: \_\_\_\_\_ Date: \_\_\_\_\_



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

Verification of Postgraduate Medical Education																					
Institution: _____ Address: _____	Attention: <b>Program Director</b> Affiliated University: _____																				
<b>Verification For:</b>	<b>Name:</b> _____ <b>SSN:</b> _____ <b>DOB:</b> _____ Individual's Name on Record (if different from above): _____																				
<b>Program Participation:</b> 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.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">PGY: _____</td> <td style="width: 70%;">Specialty/Subspecialty: _____</td> </tr> <tr> <td> <input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research                             </td> <td> <table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table> </td> </tr> </table>	PGY: _____	Specialty/Subspecialty: _____	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>											
PGY: _____	Specialty/Subspecialty: _____																				
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>															
From: _____	To: _____																				
<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>																					
<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>																					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">PGY: _____</td> <td style="width: 70%;">Specialty/Subspecialty: _____</td> </tr> <tr> <td> <input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research                             </td> <td> <table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table> </td> </tr> </table>	PGY: _____	Specialty/Subspecialty: _____	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>		<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">PGY: _____</td> <td style="width: 70%;">Specialty/Subspecialty: _____</td> </tr> <tr> <td> <input type="checkbox"/> Internship  <input type="checkbox"/> Residency  <input type="checkbox"/> Chief Residency  <input type="checkbox"/> Fellowship  <input type="checkbox"/> Research                             </td> <td> <table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table> </td> </tr> </table>	PGY: _____	Specialty/Subspecialty: _____	<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>	
PGY: _____	Specialty/Subspecialty: _____																				
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>															
From: _____	To: _____																				
<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>																					
<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>																					
PGY: _____	Specialty/Subspecialty: _____																				
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Chief Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research	<table style="width: 100%;"> <tr> <td style="width: 50%;">From: _____</td> <td style="width: 50%;">To: _____</td> </tr> <tr> <td colspan="2"> <b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> </td> </tr> <tr> <td colspan="2"> <b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/>                              RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/> </td> </tr> </table>	From: _____	To: _____	<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>		<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>															
From: _____	To: _____																				
<b>Successfully Completed?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/>																					
<b>Accredited by:</b> ACGME <input type="checkbox"/> AOA <input type="checkbox"/> LCGME <input type="checkbox"/> RSC <input type="checkbox"/> CFPC <input type="checkbox"/> RCPSC <input type="checkbox"/> APPAP <input type="checkbox"/> FMRAC <input type="checkbox"/> None of these <input type="checkbox"/>																					
<b>Unusual Circumstances:</b> Check the correct response. Omitted responses require written explanation.  If necessary, you may continue your explanation on a separate sheet of paper.	<ol style="list-style-type: none"> <li>1. Did this individual ever take a leave of absence or break from his/her training? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. Was this individual ever placed on probation? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Was this individual ever disciplined or placed under investigation? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>4. Were any negative reports for behavioral reasons ever filed by instructors? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol> <p><b>Please explain any "Yes" response from above:</b> (attach an additional sheet if necessary)</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>																				
<b>Certification:</b>  <div style="border: 1px solid black; padding: 5px; font-size: small;">                         Affix your institutional seal in this space. If no seal is available, you must have this form notarized.                     </div>	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 <u>Program Director</u> (M.D./D.O. only), or if appropriate, the Director of GME.  <table style="width: 100%;"> <tr> <td style="width: 50%;">Name: _____</td> <td style="width: 50%;">Signature: _____</td> </tr> <tr> <td>Title: _____</td> <td>Date of Signature: _____</td> </tr> <tr> <td>Tel: _____</td> <td>Fax: _____ E-Mail: _____</td> </tr> </table>	Name: _____	Signature: _____	Title: _____	Date of Signature: _____	Tel: _____	Fax: _____ E-Mail: _____														
Name: _____	Signature: _____																				
Title: _____	Date of Signature: _____																				
Tel: _____	Fax: _____ E-Mail: _____																				