Letter of Verification for Visiting Residents Rotating at Rady Children's Hospital, San Diego

(Today's Date)

Rady Children's Hospital, San Diego
Mail Code 5119
San Diego, CA 92123

Re: ***Name (First, MI, Last) and SSN of Trainee***

To Whom It May Concern:

(Name of trainee) is currently a ***(PL or PGY level)*** enrolled in our ***(type/name of residency program)*** under the leadership of ***(name of program director)***. ***(name of resident)*** is scheduled to rotate on the ***(department or service where trainee will be rotating)*** with ***(name of person responsible for resident while rotating at the children's hospital***) at Rady Children's Hospital, San Diego from ***(start date of rotation)*** to ***(end date of rotation)*** as part of his/her residency program requirements under the provisions of the written agreement established between Rady Children's Hospital, San Diego and the ***(name of institution sponsoring the residency program in which the resident is enrolled)***.

This letter certifies that ***(name of trainee)*** is in good academic standing in the aforementioned training program and our ***(name of office performing verifications below)*** has verified his/her qualifying credentials in accordance with Joint Commission on the Accreditation of Hospital Organizations (JCAHO) standards as follows:

Qualifying degrees and inclusive dates of training:

M.D.	***University of*** ***Location*** ***Dates: July (year) – June (year)*** ***Graduation Date***:
Internship:	***Name of internship (e.g. pediatrics)*** ***University of XXX*** ***July (year) – June (year)***
Residency:	***(same as above)***
Fellowship:	***Name (e.g. pediatric cardiology)*** ***Location*** ***Dates: July (year) -***

Current certifications, board certifications, state licenses, etc.:

ECFMG (if applicable): ***Certification # xxx***
Issued: Month Date

Board Certification: ***American Board of XXX***
Issued: month, year

Licensure: ***State of XXX***
License # 123-45-6789
Expiration: Month date, year

<u>Practice experience for periods of time following graduation from medical school, dental school, etc., not accounted for above:</u>

Staff Physician:

The subject resident is employed by ***(name of employer paying the resident's salary)***. Also attached for your review are copies of the his/her curriculum vitae, ECFMG certificate, if applicable, board certification, current state license(s), and a copy of his/her complete rotation schedule for the academic year in which the resident will be rotating at your facility. A copy of the medical school diploma is included if available. If not available, the statement above and signature below confirms this primary source information has been verified by our institution and is valid.

I understand that while the resident is rotating at your facility during the time period specified above, s/he may not be claimed by our facility for reimbursement purposes (i.e., Medicare or Children's Hospitals Graduate Medical Education PP reimbursement). Also, in the event of an audit, internal or external, we understand that our facility may be required to provide additional evidence attesting to the above documentation within 5 working days.

Financial Arrangements: Trainees, as employees of **XXX**, will receive pay and benefits from XXX and are prohibited from receiving compensation in any form from the training institution.

Professional Liability Coverage: XXX will provide professional liability coverage pursuant to their existing employee agreement. A copy of this liability coverage should be attached to this document.

If our staff may be of further assistance, my point of contact is (***name) at (phone;email;address)***

(signature of <u>certifying official</u>* for the hospital)
(name of certifying official)
(title of certifying official)

NOTE: The signature of the certifying official must be an original signature. Stamped signatures or signatures "on behalf of" are unacceptable.

Where the rotation schedules use abbreviations or short names for the rotations, the provider must maintain an expanded definition for each rotation. The expanded definition must explain briefly the services being performed, and the location of the service.

****A certifying official is an individual selected and empowered by the hospital to certify the legitimacy of the information contained within this letter of verification (this person may be the Chief Executive Officer, Director of Graduate Medical Education, the Medical Staff Director/Director Credentials Review and Privileging, the Credentials Coordinator, etc.).***