Verification of Residency Completion

This form serves as your attestation to the successful completion of residency training in Emergency Medicine for the physician named below. ABEM does not consider residency to be successfully completed unless all conditions are met. ABEM will verify attestations of competency by requesting the source data used for one or more attestations.

___ I attest that this physician was a resident physician in this Emergency Medicine residency program from MM/DD/YY to MM/DD/YY.

___ I attest that this physician successfully met all residency program requirements in Emergency Medicine on MM/DD/YY.

Medical Knowledge
___ I attest that this physician has the knowledge, skills, and behaviors necessary to practice autonomously in an unsupervised environment.

Patient Care
___ I attest that this physician received a sufficient (passing) performance rating for every clinical rotation (If NO, please explain in an attached letter).

___ I attest that this physician can competently and reliably provide an airway in a critically ill or injured patient regardless of patient age.

___ I attest that this physician can competently and reliably provide vascular access (including central venous access) in a critically ill or injured patient regardless of patient age.

___ I attest that this physician can provide high-quality care leading a trauma resuscitation in infants, children, and adults.

___ I attest that this physician can provide high-quality care leading an adult medical resuscitation.

____I attest that this physician can provide high-quality care leading a pediatric resuscitation.

____ I attest that this physician can provide high-quality care leading a resuscitation of the newly born.

Interpersonal and Communication skills
___ I attest that this physician effectively listens to patients and families.

___ I attest that this physician effectively communicates challenging information with patients and families.

Professionalism
___ I attest that this physician had no professionalism issues during residency. (If NO, please explain in an attached letter)

Systems Based Practice
___ I attest that this physician's care aims to advance health equity.

Practice Based Learning
___ I attest that this physician actively participated in quality improvement activities.

_______________________ ___________
Program Director Signature MM/DD/YYY

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Program Director Name (Printed)