

**Geisinger Health System**

**REQUEST FOR VERIFICATION OF INTERNSHIP/RESIDENCY/FELLOWSHIP**

**AUTHORIZATION TO RELEASE INFORMATION (Please Print or Type):**

I, \_\_\_\_\_, authorize the institution named below to release the requested information to the Office of Medical Education, Geisinger Medical Center, 100 North Academy Avenue, Danville, PA 17822-1334, for the stated purpose.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

**NAME AND ADDRESS FOR INTERNSHIP/RESIDENCY/FELLOWSHIP (Please Print or Type):**

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

(Submit/Copy this verification form as needed for each internship, residency and fellowship attended)

**VERIFICATION BY FACILITY NAMED ABOVE: (To be completed by Hospital)**

\_\_\_\_\_  
Graduate Medical Education Program

\_\_\_\_\_  
Address

\_\_\_\_\_  
Dates of Training

PGY: \_\_\_\_\_

Program Accreditation: \_\_\_\_ACGME \_\_\_\_AOA \_\_\_\_ Other \_\_\_\_Not Accredited

\_\_\_\_\_  
Person Verifying (print name and title)

\_\_\_\_\_  
Date of Verification

\_\_\_\_\_  
Signature of Person Verifying

**Affix School/Hospital Seal Here**