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GME Clearance Card Form

Graduate Medical Education

Last Name | First Name | M.I.

SSN (FULL NUMBER REQUIRED) | Date of Birth

Birthplace | Marital Status | # of Dependents

Home Program (GW, Georgetown, DeWitt, etc…) | Specialty

Medical School Attended | Degree (MD, MBBS, DO, DPM) | City, State | Grad Date

Pre-Medical/ College or University | Degree (BA/BS) | City, State | Grad Date

PGY Level | Residency Start Date | Anticipated Residency Completion Date

Previous Residency Experience (Program, Specialty, Yrs Completed, Completion Dates)

Personal Street Address | City | State | Zip

Telephone Number | Cell Phone Number

E-Mail Address

NPI Number

Virginia State License Number | Date Issued | Expiration Date

ECFMG Certification Number | Date Issued | US Citizen (Yes or No)

*****I hereby certify that all of the information on this form is true and correct. I also understand that I need to return at the start of each rotation to update my records with the Office of Graduate Medical Education.**

Signature | **Date**