Federation of STATE MEDICAL BOARDS

Resident Records and Credentials Request

Physician name: _____ _____ _____
Last First Middle

Social Security Number (Last 4 digits): _____ Date of birth: _____

Physician's email address: _____

Name of Hospital/Resident Training Program Attended: _____

Specialty/Department: _____

Attendance Dates: _____ _____
From To

Organization requesting information: _____

Contact Person: _____

Phone Number: _____

Preferred Delivery Method of Verification:

☐ Email: _____
Your email address

☐ Fax: _____
Your fax number

☐ Mail: _____
Your physical address

Payment Method: The fee for this request is $50 payable by credit card (Visa, MasterCard, Discover or AMEX).

Once this form is received by FSMB, you will receive an invoice via email.

Please provide email address for invoice: _____

Submit form

By email to: closedprograms@fsmb.org

By fax to: 817-868-4150

Federation of STATE MEDICAL BOARDS

Affidavit and Authorization for Release of Information Request

I, the undersigned, hereby certify under oath that I am the person named below, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named on this form and credentials furnished or to be furnished with respect to my request and that all documents, forms or copies thereof furnished or to be furnished with respect to my request are strictly true in every aspect.

I hereby release, discharge and exonerate the Federation of State Medical Boards, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind.

I authorize the Federation of State Medical Boards to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Physician's Printed Name: _____

Physician's Signature: _____

Date of Signature: _____

Physician's Telephone Number or Email Address: _____

Submit form

By email to: closedprograms@fsmb.org

By fax to: 817-868-4150