PROGRAM DIRECTOR/HOSPITAL REPRESENTATIVE ATTESTATION FORM - MDR/DOSR

Access this form via website at: **hawaii.gov/dcca/pvl**

TO THE APPLICANT: Complete the "*Applicant*" section of this form. Send this form to your sponsoring residency program. Your residency program director/hospital representative may complete this form. If more than one form is needed, please duplicate both pages.

NOTE: Incomplete forms will be returned and will delay the processing of your application.

APPLICANT

Name (First, Middle)	(Last)	Social Security No.:	Birthdate:

Date Served/Applied:	Capacity Served or Applied for:	Name of Hospital/Residency Program

To: RESIDENCY PROGRAM DIRECTOR OR HOSPITAL REPRESENTATIVE

I am applying for or renewal of a limited and temporary license for residency or specialty training. The Board requires this form be completed by the Program Director or Hospital Representative. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii Medical Board in connection with my application. Please complete the following questionnaire, SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and **return the material directly to the address on the following page**.

Signature of Applicant _____ Date _____

PROGRAM DIRECTOR/HOSPITAL REPRESENTATIVE

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

Please complete A and B

A. **POSTGRADUATE TRAINING:**

1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ☐ YES ☐ NO

   Starting and ending dates of appointment as a resident: Start date: _____ End date: _____

2. Evaluate the applicant's competence, conduct, and professionalism during the program: _____

3. Has the program ever had cause to remediate, restrict, remove from patient care, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ☐ YES ☐ NO

4. Has the program ever issued a notice of contract non-renewal or non-promotion? ☐ YES ☐ NO

   If response is "YES" to questions 3 or 4, please explain and attach copies of material from your records: _____

B. **SAFE PRACTICE COMMENTS:**

1. Is there anything in your files which could call into question applicant's ability to safely practice medicine under appropriate supervision? ☐ YES ☐ NO

   If response is "YES", please explain: _____

2. Derogatory information, if any: _____

(CONTINUED ON PAGE 2)

ATTESTATION FORM - MDR/DOSR

Print Name of Applicant: _____ Date: _____

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Hawaii Medical Board
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

CERTIFICATION OF PROGRAM DIRECTOR/HOSPITAL REPRESENTATIVE:

I certify that the statements, answers, and representations on this form and in the documents attached are true and correct. I understand that this certification and any misrepresentation may constitute a violation of section 710-1017, Hawaii Revised Statutes.

_____ _____
Signature of Chief of Staff, Administrator or Program Director Date

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)

Print Name: _____

Title: _____

Hospital/Residency Program: _____

Address: _____

_____

_____

Phone No.: ( ) _____

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.