



F E D E R A T I O N O F S T A T E M E D I C A L B O A R D S
O F T H E U N I T E D S T A T E S , I N C .

RESIDENT RECORDS AND CREDENTIALS REQUEST

Physician Name: _____
Last First Middle

Social Security Number: _____

Date of Birth: _____

Resident Training Program Name: _____

Specialty/Department: _____

Attendance Dates: _____
From To

Organization requesting information: _____

Contact person: _____

Phone number: _____

Delivery method (check one)

E-mail: _____
your e-mail address

Fax: _____
your fax number