



Resident Records and Credentials Request

Physician name: _____
Last First Middle

Social Security Number: _____ Date of birth: _____

Hospital/Resident Training Program Name: _____

Specialty/Department: _____

Attendance Dates: _____
From To

Organization requesting information: _____

Contact person: _____

Phone Number: _____

Delivery method:

Email: _____
Your email address

Fax: _____
Your fax address

Mail: _____
Your physical address

Payment Method: The fee for this request is \$50 payable by check, money order or Visa or MasterCard.

My check made payable to the Federation of State Medical Boards is enclosed.

My money order made payable to the Federation of State Medical Boards is enclosed.

Please charge my credit card: Visa MasterCard

Card number: _____ Expiration date: _____

Name as it appears on card: _____

Submit form

By email to: Modonnell@fsmb.org

By fax to : 817-868-4150

By mail form to: Federation of State Medical Boards, Attn: Federation Credentials Verification Service, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039.