

[Prepare letter on your school's official letterhead-then delete this line]

**TRAINEE QUALIFICATIONS AND CREDENTIALS VERIFICATION LETTER (TQCVL)  
FOR TRAINEES SPONSORED BY  
AN AFFILIATED PROGRAM OR INSTITUTION**

*Department, Program, or Sponsoring Entity  
School's Mailing Address  
City, State, Zip Code*

Anna Marie Ray, RN, MSN, ARNP  
Medical Education Coordinator (516/11B)  
Bay Pines VA Healthcare System  
PO Box 5005  
Bay Pines FL 33744

Dear Mrs. Ray:

1. I certify that the information listed in paragraph 2 has been verified for the trainees who are listed below<sup>1</sup> who are scheduled to receive clinical training at Bay Pines VAHCS from \_\_\_\_\_ Through \_\_\_\_\_:

<b>Trainee Names (First/Last)</b>	<b>SSN (last 4#)</b>	<b>Discipline of Study or Specialty</b>	<b>Degree Level or Post Graduate Year (PGY)</b>

2. In addition, I certify that these trainees:

- a. Are enrolled in the designated training program and have met criteria for this level of training;
- b. Have satisfactory health to perform the duties of the clinical training program;
- c. Have had tuberculin testing as required by the Center for Disease Control (CDC) and VA facility standards;
- d. Have had hepatitis B vaccination or have signed declination waivers;
- e. Have had chicken pox or chicken pox vaccine or have signed declination waivers;
- f. Have had primary source verification of educational credentials as required by the admission criteria of the affiliate's training program;
- g. Have had primary source verification of current licenses including provisional, temporary, or training licenses, registrations, or certifications through the state licensing boards and national and state certification bodies as required by the training program. Credentials subject to verification include all prior or current licenses, certifications, or registrations in any clinical program;
- h. Have had primary source verification of the ECFMG (Educational Council for Foreign Medical Graduates) certificates;
- i. Have provided letters of reference as required by training program.

3. I will notify the VA Designated Educational Officer or Medical Education Coordinator within 72 hours of changes in the academic status of individual trainees, adverse actions that affect the trainee appointment, or changes in health status that pose a risk to the safety of trainees, other employees, or patients.

<sup>1</sup>[1] **NOTE:** Any trainee who does not meet all of the criteria or upon whom all primary source verification has not been completed should be processed on a separate TQCVL. For these trainees, deficiencies or discrepancies should be stated explicitly and an explanation provided.

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4. I certify that all documents pertaining to the listed trainees are maintained on file and available to VA officials for review.

*Your signature is required here* \_\_\_\_\_

Name and Title of Sponsoring Entity \_\_\_\_\_  
Program Director/Telephone: \_\_\_\_\_

\_\_\_\_\_  
(Date)

Email address: \_\_\_\_\_

\_\_\_\_\_  
Received by the Designated Education Officer (Date) \_\_\_\_\_  
-or- Medical Education Coordinator  
Bay Pines VA Healthcare System  
PO Box 5005  
Bay Pines FL 33744