Prerequisite 7 – Physician Experience- Sample Form Template

(THIS IS A MANDATORY TEMPLATE CONTAINING ALL REQUIRED INFORMATION)

MADE-UP UNIVERSITY HOSPITAL
123 Main Street
Any City, Any State
888-555-1212

This form letter must be printed on official hospital/facility letterhead

[Insert Current Date]

American Registry for Diagnostic Medical Sonography
(ARDMS) 1401 Rockville Pike
Suite 600
Rockville, MD 20852-1402

Prerequisite 7 Experience Letter

To be completed by a Reporting Physician

Name of Applicant:____

Applicants Place of Employment:____

Applicant's Job Title/Position:____

Reporting Physician's Name:____

Start date of supervised work experience:____

End date of supervised work experience:____

Total number of supervised hours worked:____

Number of cases performed [insert applied for specialty area] under my supervision:____________________

The above Applicant is applying under Prerequisite 7 for the [applied for specialty area] specialty examination. In order to meet the Prerequisite 7 requirements, the Applicant must (1) document a minimum of 6,720 clinical ultrasound hours earned over a 48 month period and (2) a minimum of 3200 cases in the applied for specialty area.

I, [insert your name], can personally attest that [name of Applicant] has performed [number of studies] under my supervision which have been distributed over the major testing areas in [applied for specialty area].

I have read and interpreted [name of Applicant] cases and verify the studies presented have been of diagnostic value.

In signing this Attestation, I agree and acknowledge that:

1. This verification form may be used by the ARDMS for the purpose of certifying the Applicant in the field of medical sonography; and
2. The ARDMS certification is relied upon by both the healthcare community and consumers as reassurance that the individual performing their ultrasound examination has met national standards in regards to the knowledge, skills and abilities essential to quality sonography; and
3. I can be held responsible for any false or misleading statements contained in this document.

[Insert Signature of the Reporting Physician]
[Insert Name of the Reporting Physician]
[Insert Current Date]
[Insert Medical License Number of the Reporting Physician]
[Insert Title of the Reporting Physician]
[Insert E-mail Address of the Reporting Physician]
[Insert Phone Number of the Reporting Physician]