American College of Obstetricians and Gynecologists

Declaration of Verification by the Residency Program Director / Chair

Applicant Information

Full Name: _____

First Name *Middle Name* *Last Name* *Designation (MD, DO, MPH)*

Residency Program Information

Current Level of the Candidate in the Program / Residency Hospital:	In Progress ☐	Completed ☐
Start Date of the Program / Residency Hospital:	Month	Year
End Date or Anticipated Completion Date of the Program / Residency Hospital:	Month	Year
Residency Program Name as Specified by the RRC: (Print)		

Residency Program Director's Information

Name of Residency Program Director: (Print)	
Signature of Residency Program Director:	
Date of Residency Program Director Signature:	
Residency Program Director's Email:	

Importance Notice (read below)

All applicants are **required** to have the Program Director's signature. Applications will not be processed until the completed form is received. ACOG Membership Services can be contacted by email at membersupport@acog.org or phone at 202-863-2452.