**Final Summative Evaluation - Dismissal**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program**

Residency Name

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

First Name, MI, Last Name, Suffix

1. **Verification of Training:**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ resigned from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name Specialty or Subspecialty Name

residency training at The University of Texas Health Science Center at San

Antonio effective: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attendance dates were as follows:

 Effective date of resignation

Internship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dates of Internship

Residency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dates of Residency

*During their time in the fellowship, Dr. XXX was dismissed from the program due to failure to demonstrate progress in competency standards, including [List].*

**II. Disciplinary Action:**

During the dates of training at this institution, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was (or was not)

 Last Name

subject to any institutional disciplinary action.

 *[Description any other probationary and/or disciplinary actions. During their time in the fellowship/residency, Dr. XXX failed to demonstrate progress in competency standards, including [List]. To address these deficits, Dr. XXX was offered a structured learning program under academic probation. Dr. XXX failed to meet the expectations of the probationary period and was dismissed from the program. Dr. XXX was informed this adverse academic action will be reported to the Texas Medical Board and on future verification of training request.]*

**III. Professional Liability:**

To the best of my knowledge, Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was (or was not) investigated by

 Last Name

any governmental or other legal body and was (or was not) the defendant in any

malpractice suit during residency training.

 *[Description of investigations and malpractice suits]*

**IV. Clinical and Procedural Competence:**

The education Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ received from our training program

 Last Name

was not sufficient for the independent practice of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. At the

Specialty or Subspecialty

conclusion of residency, he/she was judged capable of performing the following procedures independently and competently, without direct supervision.

[List of procedures, if any, that can be performed independently and competently, without direct supervision]

**V. Credit for Successful Training and/or Board Certification:**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_ will receive \_\_\_\_\_ years and \_\_\_\_\_ months of credit toward

 Last Name

American Board of \_\_\_\_\_\_\_\_\_\_\_ certification but is not board eligible. [Allowable credit toward certification is highly board dependent when training is not complete. Please contact your applicable board for more information. If training does not lead to board eligibility, quantify the time of successful training (if any) given to the trainee.]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Program Director/Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name