



Graduate Medical Education  
3901 Rainbow Blvd., MS#1060  
Kansas City, KS 66160

## Authorization to Release Residency/Fellowship Information

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I authorize the University of Kansas Medical Center-School of Medicine’s Graduate Medical Education Staff to provide copies of the documents listed below to all outside facilities in which I rotate during my KUMC residency/fellowship training program:

- CV
- ECFMG-if applicable
- ERAS Application and/or Admission to Graduate Medical Education Application
- FMG English version of Medical School Certificate-if applicable
- License to practice Medicine in Kansas
- License to practice Medicine in Missouri
- Medical School Certificate
- Rotation Schedule
- TB Surveillance

\_\_\_\_\_  
NAME (please print)

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
Witness from Program  
Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Program of Training

\_\_\_\_\_  
Date