Resident Records and Credentials Request

Physician name: _____ _____ _____
Last First Middle

Social Security Number (Last 4 digits): _____ Date of birth: _____

Physician's email address: _____

Name of Hospital/Resident Training Program Attended: _____

Specialty/Department: _____

Attendance Dates: _____ _____
From To

Organization requesting information: _____

Contact Person: _____

Phone Number: _____

Preferred Delivery Method of Verification:

☐ Email: _____
Your email address

☐ Fax: _____
Your fax number

☐ Mail: _____
Your physical address

Payment Method: The fee for this request is $60 payable by credit card (Visa, MasterCard or Discover).

Once this form is received by FSMB, you will receive an invoice via email.

Please provide email address for invoice: _____

Submit form

By email to: closedprograms@fsmb.org

By fax to: 817-868-4150

Federation of State Medical Boards, Attn: Student Records, 400 Fuller Wiser Road, Euless, TX 76039