

Sponsoring Institution Name (Hospital or University name)

Program Name:

Date:

Dear Medical Center Director:

Hello, my name is _____ Program Director for the (Hospital/University)
_____ program.

CERTIFICATION LANGUAGE FROM THIS POINT ON MUST NOT BE MODIFIED

My signature on this Trainee Qualifications and Credentials Verification letter (TQCVL), certifies that verification has been made and that each health professions trainee (HPT) on the attached list is fully qualified to participate in the subject training program and meets the conditions of employment as outlined below.

Additionally, should any HPT on the attached list experience a change in their academic or health status, I will notify the facility Designated Education Officer (DEO) no later than 72 hours after the discovery. Though it is unnecessary to disclose specifics of the change, HPTs who become unqualified (e.g., are no longer enrolled or active in a program, pose a risk to the health and safety of others) will not be permitted to continue training at the VA and must be offboarded per VA policy.

I certify that each HPT on the attached list has:

- Met all requirements for enrollment and continued participation in the specified training program;
- Met all criteria for their level of training;
- Evidence or self-certification that they are physically and mentally fit to perform the essential functions of the training program, with or without a reasonable accommodation;
- Evidence or self-certification of up-to-date vaccinations for healthcare workers as recommended by Centers for Disease Control (CDC) and required by VA <https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>. VA approved immunization accommodations or medical exemptions must be submitted with this TQCVL. Evidence of tuberculosis screening or testing as recommended by CDC health care personnel guidelines <https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm>;
- Identification documents to meet VA security requirements; [PIV Credential Identity Verification Matrix \(va.gov\)](#); and
- Results of screening against the Health and Human Services' List of Excluded Individuals and Entities (LEIE). <https://exclusions.oig.hhs.gov/>.

I certify that EVERY HPT on the attached list has met ALL qualifications and required certifications for the training program including, but not limited to: (check all that apply):

- ☐ Primary source verification of current and past license(s) or registration(s) in any field
- ☐ Certification(s) through the state licensing board(s) and/or national and state certification bodies
- ☐ Drug Enforcement Administration (DEA) registration
- ☐ National Provider Identifier (NPI) registration
- ☐ Other qualifications and certifications: _____

I certify that HPTs on the attached list who meet any of the following criteria, have had their information verified as stated and therefore meet Federal appointment eligibility requirements:

- **HPTs who were born male** and who are US citizens, immigrants to the US, or are otherwise required by law to register, have registered with the Selective Service System, even if they have served in the armed forces. <https://www.sss.gov>
- **HPTs who are international medical school graduates** have had primary source verification of the Educational Council for Foreign Medical Graduates (ECFMG) certificates.
- **HPTs who currently have or previously had full unrestricted license(s)**, including licenses in other professions, have been screened against the National Practitioner Data Bank (NPDB). <https://www.npdb.hrsa.gov/>
- **HPTs who are non-US citizens:**
 - Have current immigrant, non-immigrant, exchange visitor or other documentation stating that they are eligible to live and work in the US;
 - Appropriate documents can be provided and could include permanent resident card, employment authorization document Form I-766, visas: J-1, J-2, H-4, E-3, or DS-2019;
 - Have been issued a US social security number.

Finally, **I certify** that all documents and information pertaining to HPTs on the attached list can be reviewed by contacting _____ or the individuals on attached list_____.

Signature

Date

Name and Title of Educational Official at the Affiliate

Attachment: TQCVL List of HPTs (DO NOT accept without attachment)

VA Medical Facility Chief of Staff

Accept/Do Not Accept (circle one)

William Acevedo MD
Chief of Staff, VACHS

Date

VA Medical Facility Director

Accept/Do Not Accept (circle one)

Thomas A. Steinbrunner, FACHE
Interim Executive Director

Date

cc: VA Medical Facility Designated Educational Officer