

HIGH PRIORITY

Required Notification of Exchange Visitor Physician Dismissal

ECFMG is required to monitor the activities of the exchange visitor physicians it sponsors and to update the Student and Exchange Visitor Information System (SEVIS) if/when an exchange visitor physician is released from the approved training program and site of activity. Therefore, ECFMG must be informed *immediately* of any exchange visitor physician's dismissal in advance of the originally-approved program end date listed on Form DS-2019 and/or prior to program completion. Once notified of a dismissal, ECFMG will adjust the individual's SEVIS record to reflect the new program end date and an e-mail will be sent to the exchange visitor physician notifying him/her of the action taken by ECFMG.

EXCHANGE VISITOR (EV) PHYSICIAN INFORMATION

EV Physician Name: _____ USMLE/ECFMG ID: _____

Training Institution Name: _____ Specialty / Subspecialty: _____
(Site of Activity)

DISMISSAL DETAILS

Reason for Dismissal: _____ Last Date of Program Participation: _____
(i.e., professional, academic, medical issues)

Was the EV physician provided with a written notice of intent that his/her agreement was being terminated and/or not renewed prior to the formal dismissal? If yes, please briefly describe.

Was the EV physician afforded due process related to his/her dismissal? If yes, please briefly describe.

Were there any issues related to performance/professionalism that factored into the EV's dismissal?

Yes No

Did the EV physician complete all requirements of the specialty or subspecialty training program identified above (i.e., is he/she board eligible in the identified specialty/subspecialty)?

Yes No

If training program requirements have not been met, please identify the months of credit, if any, that will be given for the current training year.

_____ Months

EV physician's forwarding mailing address, e-mail address, and phone number:

REQUIRED SIGNATURES

Program Director Name: _____ **Program Director Signature:** _____ **Date:** _____

TPL Name: _____ **TPL Signature:** _____ **Date:** _____

Exchange Visitor Physician Signature: _____ **Date:** _____

Upload the completed form and any attachments to the exchange visitor physician's current sponsorship record via EVNet (TPL) or OASIS (EV physician).