CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

[Date]

Creighton University GME
[Residency/Fellowship Program]
CUMC-Bergan Mercy
Creighton University Education Building
7710 Mercy Rd. Suite [Suite #]
Omaha, NE 68124-[+4 Zip]

Re: [Name of Trainee]
[DOB] [NPI]

Dear [Program Director Name]:

The above-referenced individual has applied for medical staff appointment and/or clinical privileges at [name of requesting entity]. This individual has indicated that he/she received training at your institution.

Your assistance in completing the enclosed form is greatly appreciated. Please fax or e-mail the completed form to [name of requesting department] at [facsimile #] and [e-mail address of requesting entity]. The individual named above has signed the enclosed authorization and release form that authorizes you to provide this information.

Should you have any questions, please contact this department at [requesting department phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Name]
[Title]
[Phone]
[E-Mail]

Enclosures: (i) Verification of Graduate Medical Education Training Form
(ii) Authorization and Release Form