<date>          Program ID: ________________

Larry R. Faulkner, M.D.
President and CEO
American Board of Psychiatry and Neurology
2150 East Lake Cook Road, Suite 900
Buffalo Grove, IL  60089

Re: <Name of resident>

Dear Dr. Faulkner:

This is to verify that Dr. <Name> entered our neurology residency program as a PGY-<year> on <month/day/year>. S/he <has/will satisfactorily> complete(d) the following training:

- ____ clinical adult neurology (at least 18 months total, 6 months outpatient, including ½ day/week continuity clinic, and minimum 6 months inpatient)
- ____ child neurology (3 months minimum)
- ____ elective time (3 months minimum)
- ____ psychiatry (1 month minimum)

_________________________________________________________________

<table>
<thead>
<tr>
<th>Clinical Skills Evaluations</th>
<th>Date Completed</th>
<th>ABPN Certified Evaluator</th>
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</thead>
<tbody>
<tr>
<td>☐ Child Neurology</td>
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<td>☐ Critical Care</td>
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<td>☐ Neuromuscular</td>
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<tr>
<td>☐ Ambulatory (headache, seizure)</td>
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<td>☐ Neurodegenerative (movement, inflammatory)</td>
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Dr. <Name> has demonstrated sufficient professional ability to practice competently and independently. There is no evidence of unethical behavior, unprofessional behavior, or clinical incompetence.

Dr. <Name> <left/successfully completed/will complete> the program on <month/day/year>.

Sincerely

<Name, MD>
Neurology Residency Director