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For Board certified/eligible Nuclear Medicine Physicians

To: Certification Board of Cardiovascular Magnetic Resonance Date: _____

I verify that *(Trainee's Name)* _____ was a

◯ Nuclear Medicine OR ◯ Nuclear Radiology Trainee from _____ (*Date*)

and ◯ has ◯ will have successfully completed _____ months of ACGME or RCPSC

RCPSC approved Nuclear Medicine training on _____ (Date) in the program for

which I am the Program Director.

_____ _____

Program Directors Signature Program Directors Name (please print)

_____ _____

Date Signed Telephone Number

_____

Email Address