## For Board certified/eligible Nuclear Medicine Physicians

To: Ce	rtificatio	n Board of Ca	rdiovascular Magnetic	Resonance	Date:	
I verify that (Trainee's Name)					was a	
Nuclear Medicine OR Nuclear Radiology T				Trainee from	(Date)	
and	has	will have su	ccessfully completed	months o	of ACGME or RCPSC	
RCPSC approved Nuclear Medicine training on				(Date) in the program for		
which	I am the	Program Dire	ector.			
Program Directors Signature				Program Directors Name (please print)		
Date Signed				Telephone Number		
					Email Address	