

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Telephone (781) 876-8230
www.mass.gov/massmedboard

Instructions for Completing Affiliation Request Form

1. All questions on the Affiliation Request Form must be answered and signed by the director at the primary and secondary facility where residents are being overseen.
2. A current curriculum vitae for the director at the major and minor facility and physicians responsible for supervising the residents in the absence of the directors must be enclosed.
3. A copy of the signed affiliation agreement between the two facilities must be attached.
4. The completed Affiliation Request Form, affiliation agreement between both facilities, and the curriculum vitae of the program directors and supervising physicians at both facilities should be returned to the Licensing Division at the above-listed address.

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Affiliation Request Form

1. Name of Major Institution: _____
2. Name of Minor Institution: _____
3. What is the specialty field of medicine? _____
4. Names of the physicians responsible for the supervision of the residents/ fellows:

5. Number of residents/ fellows rotating at one time: _____ Length of Rotations: _____
6. Rotations will be: Assigned or Electives
7. From Major institution to Minor Minor institution to Major institution
8. Duration of affiliation: (Check one) Number of Years(s) _____ or Indefinite period
9. Does the Residency Program Committee approve the rotations? Yes No
If "no" why not? _____
10. Date that the Major residency program was last surveyed: _____
What were the results of the survey? _____

Additional Affiliation Requirements

- Curriculum vitae of the supervising faculty at the Major institution and Minor Institution.
- Curriculum vitae of each fully licensed Massachusetts physician who will be participating in the supervision of the residents/fellows at the Major and Minor institution.
- A letter from the Minor Institution stating the level of supervision of the rotating residents/fellows.
- The completed Affiliation Agreement between the Major and Minor institution.

The Directors of the Health Care Facilities or Health Care Facility and the Training Program must sign below:

We hereby request approval of an affiliation between: _____
and _____

Major Institution: _____ Minor Institution: _____

Signature: _____ Signature: _____

Name: _____ Name: _____

Title: _____ Title: _____

Date: ___/___/_____ Date: ___/___/_____