Graduate Medical Education
170 Manning Drive
B132|CB #7514
Chapel Hill, NC 27599

UNC HEALTH OFFICE OF GRADUATE MEDICAL EDUCATION
Attestation of Background Investigation and Pre-Employment Drug Screening
For Visiting Residents and Fellows

Instructions
This form must be completed and signed by an authorized institutional official from the Sponsoring Institution, such as:

- Designated Institutional Official (DIO)
- Director of Graduate Medical Education (GME)
- Associate/Assistant DIO
- Medical Education Office Leader or equivalent institutional representative with authority to verify trainee background screening and credentialing records

The completed form must be submitted to the UNC Health Office of Graduate Medical Education before the visiting resident or fellow begins their rotation.

On behalf of _____ (**Sponsoring Institution**), I acknowledge and attest to the **UNC Health Office of Graduate Medical Education** that _____ (**Sponsoring Institution**) has conducted, and has in its possession, a background investigation report and pre-employment drug screening for the individual identified below.

I attest that the documentation is satisfactory in that it:

☐ Does not reveal criminal activity
☐ Confirms that the individual is not on the Office of Inspector General (OIG) Exclusion List
☐ Confirms that the individual is not listed as a violent sexual offender
☐ Confirms that no other aspect of the investigation conducted reveals information of concern
☐ Does not report confirmed positive results on the pre-employment drug screening

I further attest that there are no prior or pending investigations, reviews, sanctions, or peer review proceedings involving the individual identified below, and that there are no limitations of licensure, certification, or registration.

This attestation is provided in lieu of submitting the background investigation report and pre-employment drug screening documentation to UNC Health.

OFFICE OF GRADUATE MEDICAL EDUCATION
170 MANNING DR.
ROOM B132, CB 7514
CHAPEL HILL, NC 27514

Individual Subject to the Attestation

Name: _____
Residency/Fellowship Program: _____
Home Institution: _____
Expected Rotation Dates at UNC Health: _____

Authorized Institutional Official

I certify that I am authorized to provide this attestation on behalf of the Sponsoring Institution.
Authorized Official Signature: _____
Printed Name: _____
Title: _____
Institution: _____
Email Address: _____
Phone Number: _____
Date: _____