

Date

Certification Board of Cardiovascular Computed Tomography
1401 Rockville Pike, Suite 600
Rockville MD 20852 USA

Regarding (full name of Applicant):

To Whom This May Concern:

Dr. _____ has completed training that meets the national
training requirements for independent specialist practice of Cardiology, Nuclear
Medicine or Radiology in _____ (name of country) between
(mm/yy) and _____ (mm/yy).

This applicant **has completed** ☐ **OR** **will complete** ☐ national
registration as a specialist in Cardiology, Nuclear Medicine or Radiology
in _____ (mm/yy).

Author's Name Printed: _____

Author's Title: _____
(e.g., Program Director, Supervisor, Training Director)

Professional Relationship to Applicant: _____

Email: _____ Phone: _____

☐ I confirm that the above information is true and accurate.

Author's Signature: _____