

– SAMPLE LETTER –

**Critical Care Echocardiography Certification for Physicians who completed one year of clinical fellowship dedicated to critical care echocardiography (Requirements 4 and 5)**

ABC Hospital  
123 Main Street  
New York, NY 54321  
(212) 123-5432

Date letter was written (MM/DD/YYYY)

National Board of Echocardiography, Inc.®  
3739 National Drive, Suite 202  
Raleigh, NC 27612

RE: Physician's Full Name  
Physician's Date of Birth  
ACGME Program Number

To Whom It May Concern:

REQUIREMENT 4

This letter confirms that Dr. \_\_\_\_\_ (Name) \_\_\_\_\_ successfully completed a minimum of one year of specialized clinical training dedicated to the study of Adult Critical Care at our institution between \_\_\_(MM/DD/YYYY)\_\_\_ and \_\_\_(MM/DD/YYYY)\_\_\_ . This letter further confirms that this program is an accredited ACGME training program or other nationally accredited critical care echocardiography training program.

REQUIREMENT 5

Our records indicate that Dr. (Name)\_\_\_ had specific training in Critical Care Echocardiography and personally performed and interpreted \_\_\_\_\_ (# of cases) \_\_\_\_\_ complete critical care transthoracic echocardiograms under appropriate supervision. \_\_\_\_\_

I certify that the number of studies provided above are exact numbers and are not rounded and/or estimates.

Sincerely,

Name Title (Fellowship Director, Program Director, or Chair of Critical Care program.)

Sworn and subscribed to before me on (date): \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

NOTE: The EXACT number of studies performed and interpreted MUST be provided. Committee decisions will be determined using the numbers provided in this letter. If using a fiscal year, exact dates are required. For example, MM/DD/YY - MM/DD/ YY. Letters MUST be typed on appropriate letterhead and MUST be notarized.