Date: _____

To Whom It May Concern:

This letter will confirm that the Beth Israel Deaconess Medical Center has agreed to sponsor the physician, listed below, to participate in our clinical training program for the 2026-2027 academic year.

Full Legal Name of Trainee	
Department Name	
Program Name	
2026-2027 Program Dates	Orientation/Hire Date:_____ N/A: ☐ Training Start: _____End: _____
Program Status/PGY Level	PGY: _____ ☐ Resident ☐ Fellow
Track (if applicable)	☐ Preliminary ☐ Categorical ☐ N/A
Salary (List total, inclusive of Stipend, if applicable)	$_____
ACGME Accredited Program	☐ YES ☐ NO
Hospital Address Main Telephone	330 Brookline Avenue, Boston, MA 02215 (617) 667-7000

Should you have any questions, please contact our office via the following email: _____@bidmc.harvard.edu.

Sincerely,

PD's Signature: _____ Date Signed: _____

_____
Program Director's Printed Name

Trainee's Signature: _____ Date Signed:_____

_____
Trainee's Printed Name