



Bureau of Professional Licensing
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CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

Authority: 1978 PA 368

This form must be submitted directly to this office by the Program Director of Medical Education Office. If this form is submitted by the applicant, it will not be accepted.

Section of Form to be Completed by Applicant:

Applicant's Name (First, Middle, Last)		Date of Birth (MM/DD/YYYY)
Address		
City	State	Zip Code
Telephone Number	Email Address	
Applicant's Signature		Date

Remainder of Form to be Completed by Program Director of Medical Education

Name of Training Hospital		
Address of Hospital		
City	State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above has been duly appointed to a podiatric residency at the hospital named above

beginning _____ and ending _____,
(Month/Day/Year) (Month/Day/Year)

Is the program accredited by CPME? Yes No

 Signature of Director of Medical Education

 Date

 Print or Type Name of Director of Medical Education

(Seal) If hospital has no seal, please indicate.