

Applicant Information: Licensee's First Name Bureau of Professional Licensing PO Box 30670 ◆ Lansing, MI 48909 Telephone: (517) 241-0199

> www.michigan.gov/bpl BPLData@michigan.gov

CERTIFICATION OF PRACTICE IN AN ACADEMIC INSTITUTION

Last Name

Authority: 1978 PA 368

This form must be submitted directly to this office by the Director of Medical Education office where you practiced under a clinical academic limited license. A separate form will need to be submitted by each academic institution in which the applicant practiced under. If this form is submitted by the applicant, it will not be accepted.

Middle Name

Last 4-digits of Social Security Number	Date of Birth (MM/DD/YYYY)		10-Digit MI Permanent ID/License Number	
Remainder of Form to be Completed by Director of Medical Education:				
Name of Academic Institution				
Address of Academic Institution				
City		State		Zip Code
CERTIFICATION AND SIGNATURE				
I certify the applicant named above has functioned not less than 800 hours per year in the observation and treatment of patients for the above academic institution. In doing so, the applicant practiced medicine safely and competently				
beginningMonth/Day/Year)	(Month/Day/Ye	(Month/Day/Year)		
I further certify that the above named academic institute meets the requirements of MCL 333.17001 of the Public Health Code, Act 368 of 1978.				
Signature of Director of Medical Education	·	Date		
		(SEAL)	If hospita	al has no seal, please indicate.
Print or Type Name of Director of Medical Educ	ation			

LARA/BPL-MEDCERTCLINPRAC (Rev. 3/2025)

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