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CERTIFICATION OF COMPLETION OF POSTGRADUATE TRAINING

Authority: 1978 PA 368

This form must be submitted directly to this office by the director of medical education office. If this form is submitted by the applicant, it will not be accepted.

Licensee Information:

Form with fields: Licensee's First Name, Middle Name, Last Name, Address, City, State, Zip Code, Date of Birth (MM/DD/YYYY), Telephone Number, Email Address

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

Form with fields: Name of Hospital or Institution, Address of Hospital or Institution, City, State, Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above has successfully completed postgraduate training offered by the hospital or institution named above in the clinical area of

(Program Name)
from (Month/Day/Year) to (Month/Day/Year)

PLEASE CHECK APPROPRIATE BOX BELOW:

- MD ONLY - I further certify that this is an active program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada or the Canadian Medical Association's Conjoint Accreditation Services.
DO ONLY - I further certify that this postgraduate training is accredited by the American Osteopathic Association Council or the Accreditation Council of Graduate Medical Education.

Signature of Director of Medical Education

Date

Print or Type Name of Director of Medical Education

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

NOTE: MD ONLY- Certification of Completion of Postgraduate Training may be submitted to the department no more than 15 days prior to the scheduled date of completion. If signed and submitted sooner, it will not be accepted.

DO ONLY- Certification of Completion of Postgraduate Training may be submitted to the department no more than 30 days prior to the scheduled date of completion. If signed and submitted sooner, it will not be accepted.