Bureau of Professional Licensing
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CLINICAL ACADEMIC LIMITED LICENSE HOLDERS SEEKING FULL LICENSURE

CERTIFICATION 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:

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:

Name of Institution			
Address of Institution			
City		State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above has successfully completed not less than 3 years of postgraduate clinical training in the institution named above in the clinical area of

_____.
(Program Name)

from _____ to _____.
(Month/Day/Year) (Month/Day/Year)

I further certify that the institution named above is affiliated with a medical school that is listed in a directory of medical schools published by the World Health Organization (WHO).

_____ _____
Signature of Director of Medical Education Date

_____
Print or Type Name of Director of Medical Education (Seal) If hospital has no seal, please indicate.