Bureau of Professional Licensing
PO Box 30670 ● Lansing, MI 48909
Telephone: (517) 335-0918
www.michigan.gov/bpl
BPLHelp@michigan.gov

CERTIFICATION OF FIRST YEAR POSTGRADUATE TRAINING

Authority: 1978 PA 368

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

Applicant Information:

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

Remainder of Form to be Completed by Medical Director or Superintendent:

Name of Hospital or Institution		
Address of Hospital or Institution		
City	State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above has satisfactorily completed 1 year of postgraduate clinical training at the hospital or institution named above in the clinical area of

_____.
(Program Name)

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

I further certify this postgraduate training is accredited by the American Osteopathic Association Council or the Accreditation Council for Graduate Medical Education.

_____ _____
Signature of Medical Director or Superintendent Date

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

NOTE: This form will not be accepted more than 30 days before the completion of the first year of training.