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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:

Form with fields: Licensee's First Name, Middle Name, Last Name, Address, City, State, Zip Code, Date of Birth (MM/DD/YYYY), Last 4-digits of Social Security Number

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

Form with fields: 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 (Month/Day/Year) to (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.