FORM A

CERTIFICATE OF POSTGRADUATE TRAINING

INSTRUCTIONS: To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Either the hospital seal OR notary seal must be on this form. Errors shall be noted by one line through the error and initials of correcting party. No whiteouts or strikeouts are acceptable on this form and may result in a delay of the application process. This form may be sent with the applicant's application packet only if the original envelope is unopened, and the program director has signed his/her name across the back of the envelope. Altered envelopes which contain official, original, or certified official documents will not be accepted.

PART 1: TO BE COMPLETED BY THE APPLICANT.

Name: _____ Date of Birth: _____ SSN: _____

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR.

Every effort should be made by the training program to complete this form as accurately as possible. However, the Georgia Composite Medical Board does understand that programs close and facilities merge making records unavailable. The Federation of State Medical Boards has offered all Accreditation Council of Graduate Medical Education approved programs which have closed the opportunity to permanently store their resident records. Additionally, a few American Osteopathic Association approved programs and other training programs have sent resident records to the Federation. This will provide a central repository for those entities requiring verification of physicians' credentials.

US and Canadian Medical School Graduates: Please provide the training dates. If the program is in progress, you may provide the "to" date as the date which the training is scheduled to be completed. This will provide the current standing of the training.

International Medical School Graduates: **Do not complete this form unless the training requirement has been completed**. As of February 5, 2010, the Georgia Composite Medical Board voted to utilize the *Medical Schools Recognized by the Medical Board of California* (MSRMBC) as its official reference for approval of medical schools outside the US and Canada. The list may be viewed online at http://www.mbc.ca.gov/applicant/schools.html Graduates are required to complete training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) as follows:

If school is recognized by MSRMBC, one year (1) year
If school is not recognized by MSRMBC, three (3) years

Please print, type or stamp the following information:

Name of Program: _____

Sponsored by: _____

Program ID: _____

Address: _____

City, State, Zip: _____

Affiliated University:

Georgia Composite Medical Board Use Only

AMA _____

AOA _____

RCPSC _____

CFPC _____

It is further certified that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Council on Postdoctoral Training (ECCOPT), RCPSC, or CFPC for the training of medical and osteopathic interns, residents, fellowships, and research as an Accredited Program, Graduate Medical Education Teaching Institution, or Osteopathic Postdoctoral Training Program. This is to certify that the applicant name in Part 1 has completed, not completed, or the training is in progress as follows:

☐ Internship from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Residency from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Chief Residency from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Fellowship from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

☐ Research from ___/___/____to ___/ ___/____ Specialty/subspecialty _____ Completed: ☐ Yes ☐ No ☐ In Progress

If "YES" to any of the following questions, please provide a written explanation and supporting documentation:

Any leave of absences requested/reported?	☐ Yes	☐ No
Any probationary action ever taken?	☐ Yes	☐ No
Any disciplinary actions or investigations?	☐ Yes	☐ No
Any special requirements or limitations due to questions of academic incompetence, disciplinary problem, etc	☐ Yes	☐ No

Completion of this form will certify that the individual named in Part 1 above completed a period of accredited postgraduate training at this facility. This form shall be signed by the Program Director (MD or DO only).

Program Director's Name _____ Notary's Name _____

Signature _____ Date _____ Notary Signature _____

Affix the institutional seal in this space. If you have no seal available, you are required to have this form notarized.