FORM B
CERTIFICATE OF POSTGRADUATE TRAINING

INSTRUCTIONS: To be completed by the facility for every medical school graduate completing postgraduate training. 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.

Please print, type or stamp the following information:

Name of Program: _____

Sponsored by: _____

Program ID: _____

Address: _____

City/State/Country: _____ PostalCode: _____

Affiliated University: _____

Georgia Composite Medical Use Only

AMA/AOA Year _____

AMA/AOA Page _____

RCPSC Year _____

RCPSC Page _____

CFPC Internet _____

This is to certify that the applicant name in Part 1 of this form has successfully completed (please check one)

____Internship _____Residency _____ Chief Residency _____Fellowship ____Research

from _____/_____/_____ to _____/ _____/_____ in the specialty/subspecialty of _____.

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

If "YES" to any of the above questions, please provide a written explanation.

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

Signature Date

Notary's Name

Notary Signature

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