# Georgia Composite Medical Board

## CERTIFICATE OF POSTGRADUATE TRAINING

**INSTRUCTIONS TO APPLICANT:** Ask each training program you participated in to complete this form and email it to the Board.

**PART 1: APPLICANT INFORMATION**

Name: _____ Date of Birth: _____ SSN: _____

**PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR**

**Instructions to Program Director:**

1. 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. Every effort should be made by the program to complete this form as accurately possible. If you are unable to answer any of the questions because the records related to the trainee's performance and evaluations are unavailable, please note that in the applicable section on this form.

2. Either the hospital seal or a notary seal must be on this form. Institutional seal (or notary stamp) must be visible on scanned copy.

3. Note any corrections by striking the incorrect item and initialing the correction. Do not use correction tape, fluid, etc.

4. Send the completed form to the Board via email (**GCMB.Physician@dch.ga.gov**). Email must come from the Program Director or other GME program official. The applicant's name should be in the email's subject line.

**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.