

2026-2027 CERTIFICATE OF POSTGRADUATE TRAINING FORM - RENEWAL

Permit Number: _____

PART 1: To be completed by the Resident or Fellow

LAST NAME

FIRST NAME

MIDDLE INITIAL

DATE OF BIRTH

TELEPHONE NUMBER

HOME:

WORK:

CURRENT GEORGIA GME OFFICE ADDRESS:

CITY

STATE

ZIP CODE

PART 2: To be completed by the Program Director

INSTITUTION:

INDICATE THE YEAR OF TRAINING BELOW:

PGY1

PGY2

PGY3

PGY4

PGY5

PGY6

PGY7

Name of Training Program (i.e., Internal Medicine, Psychiatry) _____

Must Complete:

Initial GEORGIA RTP Start Date:

Projected GEORGIA RTP Completion Date:

This portion of the application must be completed by the Program Director who is licensed in Georgia.

PROGRAM DIRECTOR'S AFFIDAVIT

I hereby recommend the above applicant be renewed a postgraduate training permit. I hereby certify that he/she will limit his/her practice to such acts as may be prescribed by or incidental to the training program, that he/she may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. **I understand that I must report to the Board the following within 15 days of the event: any disciplinary action taken against the permit holder for any ground or violation enumerated in O.C.G.A. §§ 43-34-37 and 43-1-19, the permit holder's withdrawal or termination from or completion of a postgraduate training program, or the permit holder who has an unauthorized absence from the program for any length of time in excess of two weeks. I HEREBY RECOMMEND THE ABOVE APPLICANT FOR ADVANCEMENT TO THE NEXT LEVEL AS REQUIRED IN 360-2-.12(4)**

Please type or print:

Program Director's Name

Title

Signature

Date

IMPRINT PROGRAM OR
NOTARY SEAL HERE

Sworn to and subscribed before me this

____ day of _____, _____
DATE MONTH YEAR

SIGNATURE OF NOTARY PUBLIC or PROGRAM COORDINATOR

My Commission Expires: