

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.

Attention Program Director: Do not sign and date this form before the last day of any postgraduate training year that will be used by the applicant to qualify for licensure. Requirements for licensure in Georgia:

US and Canadian Medical School Graduates: One (1) year [Programs may certify one year of a 2 or 3 year program to meet the requirement]

International Medical School Graduates: 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:

1. If school is recognized by MSRMBC, one year (1) year
2. 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 Code: _____
 Affiliated University: _____

This area for Georgia Composite Medical Board 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 _____.

It is further certified that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or by the Council on Postdoctoral Training (ECCOPT) 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.

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

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.