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 Medical School Graduates: One Year **Int'l Medical School Graduates: Before July 1, 1985: One Year After July 1, 1985: Three Years**

Please print, type or stamp the following information:

Name of Program: _____

Sponsored by: _____

Program ID: _____

Address: _____

City/State: _____ Zip Code: _____

Affiliated University: _____

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

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.