If you are using FCVS do not submit this form.

Complete verifications must be sent directly from the chairman/director of the post-graduate training program to the board office by fax to (850) 412-1268 or by mail to:

Board *of* Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257

Board *of* Medicine
Post-Graduate Training Verification

Name: ____

Part I: To be completed by applicant

Institution Name: ____

Department: ____

Address: ____

City: ____________________ State: ____________________ ZIP: __________

Phone Number: ______________________________

Part II: To be completed by Training Institution

The above-named doctor has applied for licensure in the state of Florida. Please complete this section and submit to the above address.

1. Dates of internship/residency/fellowship: ____________ to ____________
   MM/DD/YYYY MM/DD/YYYY
2. Matriculation date: ____________
   MM/DD/YYYY
3. Completion date: ____________
   MM/DD/YYYY
4. Specialty: ______________________
5. The levels completed under your purview:

PGY I	PGY II	PGY III	PGY IV	PGY V

6. Accredited by:

ACGME	RCPSC	CFPC	Other: ____________________

Program Director/Chair Name ____

Signature ____ Date ____________
MM/DD/YYYY