POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Name of School

Department

Address

City, State, Zip

1. Name of Resident: ____________________________________________

2. Internship/Residency/Fellowship: From: _______________ To: _______________

3. Matriculation Date: ____________

4. Completion Date: ____________

5. Specialty: ____________________

6. Levels completed (check all that apply):

   PGY I   PGY II   PGY III   PGY IV   PGY V

Signed:______________________________________________

Chairman or Program Director Only
(No stamped signatures please).