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).