

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING (Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle
1.	If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.		
2.	Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.		
3.	If training was completed at more than one hospital, duplicate this form and submit to each hospital.		

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR WHERE THE GRADUATE TRAINING OCCURRED

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director thirty (30) days prior to the completion of the approved training. Forms postmarked or signed prior to the thirty days will not be accepted.

HOSPITAL WHERE TRAINING WAS COMPLETED:					
NAME OF SPONSORING INSTITUTION:					
LOCATED IN:		CITY	STATE		ACGME ACCREDITED
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY		Yes No
PGY LEVEL	FROM (MM/DD/YYYY)	TO (MM/DD/YYYY)	SPECIALTY		Yes No

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified." If there has been disciplinary or administrative action regarding this applicant, please provide a separate statement outlining the details.

If the hospital has no seal or stamp to affix to this document, I will have the form notarized to verify that it was completed by this hospital.

Signature of Program Director

Date

(Seal)

Notary Signature

Notary Commission Expiration Date: _____

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE