PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE

VERIFICATION OF AOA APPROVED INTERNSHIP

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

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

If internship was in Pennsylvania, information must coincide with data on graduate license. This form may NOT be submitted prior to completion of the internship.

HOSPITAL WHERE TRAINING WAS COMPLETED:			
NAME OF SPONSORING INSTITUTION:			
LOCATED IN:	CITY		STATE
INTERNSHIP COMPLETED:	**FROM** (MM/DD/YYYY)	**TO** (MM/DD/YYYY)	

"I certify that the above named applicant successfully completed/will successfully complete this AOA approved internship and that there was/is no disciplinary or administrative action outstanding against this applicant. If there has been disciplinary 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 OSTEOPATHIC MEDICINE** **P.O. BOX 2649** **HARRISBURG, PA 17105-2649** **717-783-4858**	**Courier Delivery Address** **STATE BOARD OF OSTEOPATHIC MEDICINE** **2601 NORTH THIRD STREET** **HARRISBURG, PA 17110**

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE