

**Federation of State Medical Boards  
PO Box 619850, Dallas TX 75261-9850  
Telephone (817) 868-4041**

**USMLE STEP 3  
CERTIFICATION OF RESIDENCY TRAINING FORM - Hawaii**

This section is to be completed by the applicant and forwarded directly to the Program Director. **(Please print)**  
*Note:* It facilitates processing when the PGT form accompanies the Step 3 application. PGT form(s) dated more than 45 days before receipt of the application are not considered current and will not be accepted.

USMLE ID # \_\_\_\_\_ Step 3 State Board \_\_\_\_\_ Date of Birth \_\_\_\_\_

Physician Name \_\_\_\_\_ SS#(optional) \_\_\_\_\_  
(PLEASE PRINT- Last Name, First Name, Middle Name)

Hospital Name \_\_\_\_\_  
(complete name of hospital or university)

City \_\_\_\_\_ State \_\_\_\_\_ Phone # \_\_\_\_\_

I hereby authorize the release of all pertinent information, favorable or otherwise, to FSMB.

\_\_\_\_\_  
Signature Date

**This section must be completed by the Residency Director, signed, notarized, and forwarded to the FSMB at the above address by 9/3/10 for the 2010 USMLE Step 3. Original signatures and notary seal required.**

I certify that the physician named above is serving / has served \_\_\_\_\_ months / years  
(CIRCLE ONE) (CIRCLE ONE)  
of post-graduate training at the hospital named above. Accredited by one of the following associations:  
(please check one)

\_\_\_ ACGME - Accreditation Council for Graduate Medical Education \_\_\_ AOA - American Osteopathic Association  
\_\_\_ RCP - Royal College of Physicians \_\_\_ CMA - Canadian Medical Association  
\_\_\_ RCPSC - Royal College of Physicians and Surgeons of Canada \_\_\_ CFPC - College of Family Physicians of Canada  
\_\_\_ Other - \_\_\_\_\_

Date post-graduate training began / will begin: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(CIRCLE ONE) MONTH DAY YEAR

Date post-graduate training was / will be completed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(CIRCLE ONE) MONTH DAY YEAR

Please evaluate applicant's competence and conduct during the program: (Use additional paper as necessary.)

Have there been any unusual circumstances during this applicant's participation in the program? If YES, please explain: (Use additional paper as necessary.)

|   |     |    |
|---|-----|----|
| Did the applicant ever take a leave(s) of absence or break(s) from your program?  | Yes | No |
| Was applicant ever placed on probation?   | Yes | No |
| Was applicant ever disciplined or placed under investigation?   | Yes | No |
| Were there any negative reports filed against applicant?  | Yes | No |
| Were there any limitations or special requirements imposed on applicant, i.e., academic, incompetence, disciplinary problems or for any other reason? | Yes | No |

\_\_\_\_\_  
Signature of Residency Director

\_\_\_\_\_  
Print Name of Residency Director

Sworn to and subscribed before me on this the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.  
Day Month Year

**NOTARY  
STAMP or SEAL  
HERE**

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Date Commission Expires

**All items must be completed in their entirety. Any form not completed appropriately will not be accepted. No alterations of this form will be accepted.**