

**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 stamp or 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 NOTARY 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.**