

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

USMLE STEP 3
CERTIFICATION OF POST-GRADUATE TRAINING FORM – Massachusetts

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 # _____ Date of Birth _____ SS# (optional) _____

Physician Name _____
(PLEASE PRINT- Last Name, First Name, Middle Name)

Hospital Name _____
(complete name and address 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 Program Director, signed, notarized, and forwarded to the FSMB at the above address by 9/3/2010 for the 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
 CMA - Canadian Medical Association CFPC - College of Family Physicians of Canada
 RCPSC - Royal College of Physicians and Surgeons of Canada
 Other - _____

Exceptions:

- Sub-specialty clinical fellowship program – hospital has ACGME approved program in the parent specialty – verification attached.
 Teaching experience meeting all of the following requirements must be approved by the Board:
1. Consists of a faculty appointment at or above the assistant professor level; 2. Teaching is at a medical school accredited by the LCME; 3. The majority of the teaching experience documented is clinical teaching; 4. Candidate has supporting evidence of special honors or awards he/she has achieved, and articles which he/she has published in reputable medical journals or medical textbooks. **(Documentation of items 1-4 must be provided)**

Date PGT began / will begin: ____/____/____ Date PGT was/will be completed: ____/____/____

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 Program Director

Print Name of Program 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.