

Federation of State Medical Boards
400 Fuller Wisner Rd., Suite 300, Euless, TX 76039-3856
Telephone (817) 868-4041

USMLE STEP 3
CERTIFICATION OF POST-GRADUATE TRAINING FORM - Ohio

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 stamp or notary seal required.

I certify that the physician named above is serving / has served (circle one) _____ months / years (circle one) of post-graduate training at the hospital named above indicated below: (please check one)

- _____ internship or residency program accredited by the ACGME or AOA
- _____ a clinical fellowship in the US at an institution having an accredited residency program in the same or a related field
- _____ an internship in Canada accredited by the committee on accreditation of pre-registration physician training programs of the Federation of Provincial Medical Licensing Authorities in Canada
- _____ a residency program in Canada accredited by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)

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 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 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.
Rev OH PGT 2010