

**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 - Pennsylvania**

**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 or Director of Medical Education, certified with hospital seal, forwarded to the FSMB at the above address by 9/3/2010 for the 2010 USMLE Step 3. Original signatures and hospital seal required.**

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

- ACGME - Accreditation Council for Graduate Medical Education  
 RCPSOC - Royal College of Physicians and Surgeons of Canada

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

\_\_\_\_\_  
Date signed

**HOSPITAL  
SEAL (ONLY) HERE**

**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.**