Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF POSTGRADUATE TRAINING FOR USMLE EXAMINATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, you will be ineligible to sit for the exam

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICATION INFORMATION

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Street Address

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

Name

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital

Street Address of Hospital

City, State and ZIP Code

I certify that ______________________________, a graduate of the
(Applicant's Name)

______________________________ medical school, has successfully completed postgraduate

clinical training offered by the hospital named above from ______________, to ______________,
Month/Day/Year Month/Day/Year

in the clinical area of ______________________________.

Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training programs of the Canadian Medical Association?

☐ Yes ☐ No

Signature of Director of Medical Education

Date of Signature

Print or Type Name of Director of Medical Education

(S E A L)

If hospital has no seal, please indicate

NOTE: This form may not be completed and submitted to the Board office prior to the completion of the required 6 months of post graduate training. In order to be made eligible for the USMLE examination, the required training must be completed and verified by the established deadline date.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.