

Fifth Pathway Form

Name and address of the medical school that awarded the Fifth Pathway Certification (do not abbreviate)

Name of Institution

Address

City, State, ZIP Code

Name and address of hospital or clinic in which you performed the required rotations

Name of Institution

Address

City, State, ZIP Code

Attendance Dates

Exact Date Certificate was Issued

From: _____ To: _____
MM DD YYYY MM DD YYYY

_____ MM DD YYYY

Rotations

Type of Rotation	Dates Attended (MM/DD/YYYY)		Number of Weeks Credit
	From	To	

Unusual Circumstances (Circle Yes or No)

Did you take a leave(s) of absence or break(s) from this program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any negative reports for behavioral reasons ever filed by instructors?	YES	NO
Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason?	YES	NO

Please explain any "Yes" responses from above. _____

Note: Please provide a legible, complete photocopy of your Fifth Pathway Certificate.