Complete verifications must be sent directly from the training evaluator to the board office at info@floridasosteopathicmedicine.gov, or mailed to:

Board *of* Osteopathic Medicine
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-3257

Board *of* Osteopathic Medicine
Postgraduate Training Evaluation Form

Name: _____

Part I: To be completed by applicant

Institution Name: _____

Department: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____
Input without dashes

Part II: To be completed by Training Institution

The above-named doctor has applied for licensure in the state of Florida. Please complete the entire form and affix the hospital seal. If your hospital has no seal, indicate that on this form.

1. Dates of attendance: _____ to _____
   MM/DD/YYYY MM/DD/YYYY
2. The levels completed under your purview: ☐ Internship/PGY I ☐ PGY II ☐ PGY III ☐ PGY IV ☐ PGY V
3. Has the physician named above completed an **AOA or AGME accredited** internship or residency of not less than 12 months? ☐ Yes ☐ No
4. Select the physician's overall rating from the selection below (If 3 is selected, explain on a separate sheet):

   ☐ 1. Outstanding ☐ 2. Qualified/Competent ☐ 3. Less than Satisfactory

Program Director/Chair Name _____

Signature _____ Date _____
MM/DD/YYYY

Affix Hospital Seal