FORM 2PGT

MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

To be used only by applicants:

- ***not using FCVS who need to verify approved postgraduate training programs in the US and Canada;***
- ***using FCVS who had not completed training when their FCVS profile was submitted to the Office of the Professions.***

APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a Director of Medical Education, the forms may be completed by the Department Chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: ___ - __ - ____

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE: __ __ __

Month Day Year

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last

First

Middle

4 MAILING ADDRESS:

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

5 Print name under which postgraduate training was completed: ____________________

6 Hospital in which postgraduate training was completed: ____________________

Address: ____________________

7 I request and give my permission to the hospital listed in item 6 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: ____________________ Date: _______ / _______ / _______

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form ***directly*** to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that ____
(Physician's name)

a graduate of ____
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at ____________________

____
(Name and location of Hospital) ***(Accreditation Number)***

Level of Training (example: PGY-1)	Clinical Area	Inclusive dates *(mm/dd/yy)*	Successfully completed
		____ / ____ / ____ to ____ / ____ / ____	❑ **YES** ❑ **NO** ❑ **In progress; satisfactory to date**
		____ / ____ / ____ to ____ / ____ / ____	❑ **YES** ❑ **NO** ❑ **In progress; satisfactory to date**
		____ / ____ / ____ to ____ / ____ / ____	❑ **YES** ❑ **NO** ❑ **In progress; satisfactory to date**
		____ / ____ / ____ to ____ / ____ / ____	❑ **YES** ❑ **NO** ❑ **In progress; satisfactory to date**
		____ / ____ / ____ to ____ / ____ / ____	❑ **YES** ❑ **NO** ❑ **In progress; satisfactory to date**

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

❑ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: ______________________________ Date: ____ / ____ / ____

Type or print name of Director/Chair: ______________________________

Title or official position: ______________________________

Institution: ______________________________

Address: ______________________________

____

Telephone: ____________________ Fax: ____________________

E-mail Address: ______________________________

Return this form directly to:

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000