# Postgraduate Education Verification

(Copy this form for multiple programs)

**Return to :** **West Virginia Board of Osteopathic Medicine**
405 Capitol Street, Suite 402 Charleston, WV 25301
Phone: (304) 558-6095; Fax: (304) 558-6096, www.wvbdosteo.org

In applying for a license to practice medicine and surgery, the West Virginia Board of Osteopathy requires this form to be completed by **each hospital wherein I participated in any postgraduate training program** in the United States or Canada.

Name: ____________________________________________

Name if different when certificate awarded: ____________________________________________

Social Security: ______________________________ DOB: ____________________

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

**Waiver for release of information:** I authorize the Postgraduate Training Program below to provide any and all information pertaining to my medical education at your institution to the above listed Medical Board:

______________________________ ______________

Applicant's Signature Date

**This section to be completed by the office of the Administrator of the institution or program wherein the applicant participated in an approved postgraduate training program in the United States or Canada**.

This is to certify that ______________________________, D.O., undertook and completed ______ months

at ____________________________________________

(full name and complete address of Hospital)

____________________________________________

in the field of ______________________________ from ________________ to ________________

(MO/DAY/YR) (MO/DAY/YR)

Was program approved for postgraduate training during that period? Yes_______ No_______

**If "Yes", by whom? (AOA, ACGME…):** ____________________

Did this individual ever take a leave of absence or break from his/her training? Yes_______ No _______

Was this individual ever placed on probation, restricted, or limited? Yes_______ No _______

Was there any reason not to continue applicant in training program? Yes_______ No _______

Did the applicant have any medical condition, which in any way impaired or limited his/her ability to safely practice any field of medicine? Yes_______ No_______

Ability to practice medicine is to be construed to include all of the following:

- The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
- The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

*If you answered "Yes" to any questions please attach written explanation.*

**I certify that to the best of my knowledge and belief, the forgoing is a true, accurate and complete statement of the record of the individual named on this form.**

Signature: ______________________________

Affix Institutional Seal Here
(If no seal is available, this form must be notarized)

Print Name: ______________________________

Title: ______________________________

Date: ______________________________