POSTGRADUATE TRAINING EVALUATION FORM

Institution Name: ____________________________________________________________
Department: ________________________________________________________________
Address: ______________________________________________________________________
City, State, Zip: _____________________________________________________________
Phone Number: _____________________________________________________________

The doctor named below 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, please indicate such on this form.

NAME: ______________________________________________________________________

PLEASE VERIFY:

1. Dates attended (start and end): ______________________________________________

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 approved, 12 month, Rotating Internship?  YES___ NO___

OVERALL EVALUATION: If 3 is checked, please explain on a separate sheet.

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

__________________________________________  ________________________________
Name of Program Director/Chair  Signature

____________________________
Date

AFFIX  
HOSPITAL  
SEAL

DH-MQA 1029, Revised 07/16
64B15-12.003, F.A.C.