**Florida Board of Osteopathic Medicine**
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

**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:** _____

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**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**