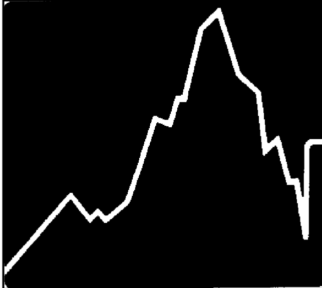
Rev. 8/07 INTERN/RESIDENT Form B

Print Name: ________________________________



Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463 **(804) 367-4570**

CERTIFICATE OF PROFESSIONAL EDUCATION

(For graduates of approved programs only)

It is hereby certified that____
(Name of Applicant)

enrolled in ______________________________ on ______________________________
(Course of Study) (Date)

and received a diploma from ____
(Name of Institution)

conferring the degree of ______________________________ on ______________________________.
(Degree) (Date)

______________________________ ______________________________
(President, Secretary or Dean)

SCHOOL SEAL

Completed form must be mailed to:

Pam Smith
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

This form will not be considered valid if submitted prior to actual date of graduation.