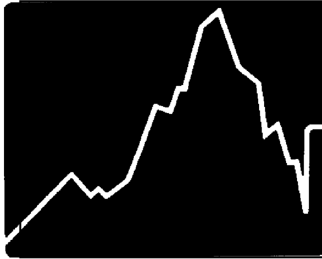

Department of Health Professions
Commonwealth of Virginia

Board of Medicine
9960 Mayland Drive, Ste. 300 **FAX (804)-527-4426**
Henrico, Virginia 23233-1463 **Phone (804) 367-4600**

TRANSFER REQUEST

Name of Licensee______________________

Training License #______________________

To: **Virginia Board of Medicine**

From: **Associate Dean of Graduate Medical Education or Program Director**

Name of Training Institute: ____

Attention: ____

Complete Mailing Address: ____

____

Telephone: ____

This is to certify that ______________________________________will be enrolled in ______________________________________
Name of Intern/Resident Specialty

at____, ____
Name of training facility in Virginia Street Address

____
City, State and Zip Code

from ____ with an expected completion date of __________________________________
(Month/Day/Year) (Month/Day/Year)

Dr. ____ is a graduate of ____
Name of Intern/Resident Medical School

We have character reference letters on file for him/her in the program office.

____
President, Secretary or Dean, or Program Director

____
Signature