



Department of Health Professions
Commonwealth of Virginia

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

(804) 367-4570

MEMORANDUM

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