Rev. 2/21 INTERN/RESIDENT FORM

Print Name: _____

Department of Health Professions
Commonwealth of Virginia

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

Telephone: (804) 367-4600
Facsimile: (804) 527-4426

CERTIFICATE OF PROFESSIONAL EDUCATION (FORM B)

(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 sent to:

Attention – Intern/Resident Applications
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.