



STATE OF NEW MEXICO
Regulation and Licensing Department
Boards and Commissions
BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
2550 Cerrillos Road, Santa Fe, New Mexico 87505
P.O. Box 25101, Santa Fe, New Mexico 87504

CERTIFICATION OF POST GRADUATE TRAINING

This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Osteopathic Medical Examiners.

PRINT FULL NAME

ADDRESS

DATE OF BIRTH

CITY, STATE, ZIP

SIGNATURE

DATE

This certifies that _____ D.O., satisfactorily completed a(n)
(PHYSICIAN'S NAME)

_____ from _____ month/year to _____ month/year program
(INTERNSHIP/RESIDENCY) (INCLUSIVE DATES) (INCLUSIVE DATES)

at _____
(HOSPITAL/INSTITUTION NAME) (STREET ADDRESS)

_____ (CITY AND STATE) _____ (PHONE NUMBER)

This program is, and has been, accredited by the American Osteopathic Association.

(SIGNATURE OF PROGRAM DIRECTOR)

(PRINT NAME, PROGRAM DIRECTOR)

(DATE)

**THIS FORM WILL NOT BE ACCEPTED IF RETURNED BY THE APPLICANT
RETURN DIRECTLY TO THE ABOVE ADDRESS**