

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**CERTIFICATION OF
POSTGRADUATE CLINICAL TRAINING**

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.

1. NAME LAST FIRST MIDDLE HASKELL SUSAN CAROL	2. DATE OF BIRTH Month Day Year [REDACTED]	3. SOCIAL SECURITY NUMBER [REDACTED]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED]	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. PHYSICIAN 3 3 6 Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME [REDACTED]	8. ISSUANCE DATE	
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)		

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 12 months of postgraduate clinical training in Internship
(Name of Specialty Program)

from 07/01/1980 to 06/30/1981 at the following hospital:
MM/DD/YYYY MM/DD/YYYY

Hospital: Des Moines General

Number and Street: _____

City, State and Zip Code: Des Moines, IA

I further certify that at the time of such training the program was accredited by:

☐ the ACGME
☒ the AOA

☐ the CFPC, RCPSC or FMLAC (Canadian Programs)
☐ not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: GME Manager

Signature of Postgraduate Clinical Training Program Director: Deb Bagnall

Date of this Certification: 2-6-18

Telephone No: 515-648-8791

University/Hospital
SEAL

(If no seal, attach letter on letterhead
stating no seal exists.)