

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. FEES ARE NOT REFUNDABLE.
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME Physician	2. PROFESSION CODE 0 3 6	3. LICENSURE METHOD Endorsement	4. FEE \$ 300.00
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|--|--|
| <input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|--|--|

PART II: Applicant Identifying Information—You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE Nagpal Geeta	2. TITLE (e.g., M.D., D.D.S., etc.) M.D.	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY [REDACTED]	ZIP CODE [REDACTED]	COUNTY [REDACTED]
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY 15 Parkman Street WACC-340 Boston, MA	ZIP CODE 0 2 1 1 4 - 2 6 9 6	COUNTY Suffolk
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6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) Nagpal	7. MOTHER'S MAIDEN NAME [REDACTED]
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8. PLACE OF BIRTH CITY STATE/COUNTRY [REDACTED]	9. DATE OF BIRTH [REDACTED]	10. AGE 31 <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male
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11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: [REDACTED] Home: [REDACTED] Fax: [REDACTED] Fax: (____) _____	12. PREFERRED e-MAIL ADDRESS(ES) (If available) [REDACTED]
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NAME (Last, First, MI):

Nagpal, Geeta

SS#:

Profession:

Physician

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)
 1 2 3 4 5 6 7 8 9 10 11 **(12)** Graduated High School? Yes No Received OR G.E.D.? Yes No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED: San Clemente High School
 3. LAST PRELIMINARY SCHOOL LOCATION (City and State): San Clemente, CA
 4. DATE OF GRADUATION: 06/1998
Month Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)
 1 2 3 4 5 6 7 **(8)** Graduated? Yes No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		TYPE OF DEGREE EARNED
		FROM <small>Month/Year</small>	TO <small>Month/Year</small>	
Massachusetts Institute of Technology	Cambridge, MA	09/98	6/02	Bachelor of Science
University of San Francisco, California School of Medicine	San Francisco, CA	09/02	6/06	M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM <small>Month/Year</small>	TO <small>Month/Year</small>	
California Pacific Medical Center	San Francisco, CA	06/06	06/07	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Brigham and Women's Hospital	Boston, MA	07/07	06/10	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Massachusetts General Hospital	Boston, MA	10/10	current	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME (Last, First, MI):

Nagpal, Geeta

SS#:

Profession:

Physician

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Massachusetts	Physician	240549	5/19/2010	Active
State of Current Licensure where you most recently have been practicing. Massachusetts	Physician	240549	5/19/2010	Active
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE Step 1	CA	04/04	
USMLE Step 2 CK	CA	02/06	
USMLE Step 2 CS	CA	02/06	
USMLE Step 3	CA	11/06	

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI): Nagpal, Geeta

SS#:

Profession:

Physician

PART VI: Personal History Information (This part must be completed by all applicants)		YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.			<input checked="" type="checkbox"/>
2. Have you been convicted of a felony?			<input checked="" type="checkbox"/>
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.			
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.			<input checked="" type="checkbox"/>
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.			<input checked="" type="checkbox"/>
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.			<input checked="" type="checkbox"/>

PART VII: Examination Coding Information (This part is for examination applicants only)

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes.

b) CHART III - Select the examination site you desire and enter Test Center Code:

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c) CHART IV - Find your School of Graduation and enter school code:

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d) Record the number of times you have taken this exam in Illinois or any other state:

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PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.

Are you more than 30 days delinquent in complying with a child support order? Yes No

(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes No

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

 Applicant

8/4/11
 Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
Nagpal Geeta

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
<input checked="" type="checkbox"/> Permanent Physician License	036
<input type="checkbox"/> Temporary Physician Training License	125
<input type="checkbox"/> Chiropractic Physician License	038

3. ADDRESS STREET, CITY, STATE, ZIP CODE
[REDACTED]

4. DATE OF BIRTH
[REDACTED]

5. SOCIAL SECURITY NUMBER
[REDACTED]

6. MAIDEN OR GIVEN SURNAME
Nagpal

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
Massachusetts General Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE
15 Parkman Street Boston, MA 02114
WACC-340

DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
 From 10/14/2010 50
Month Day Year

To ___/___/___
Month Day Year

TOTAL TIME WORKED (Year/Month)
9.5 months (current job)

JOB TITLE
Anesthesia and Critical Care Fellow

DESCRIPTION OF DUTIES PERFORMED
Clinic based care for patients with chronic pain focused on history of physical, medical management, interventional therapy, psychiatry, psychology, cancer pain, pediatrics, neurology, palliative care.

B. NAME OF BUSINESS / INSTITUTION
Brigham and Women's Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE
75 Francis Street, CNLI Boston, MA 02115

DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
 From 07/01/2007 60
Month Day Year

To 06/30/2010
Month Day Year

TOTAL TIME WORKED (Year/Month)
3 years

JOB TITLE
Anesthesia Resident

DESCRIPTION OF DUTIES PERFORMED
Patient care in pre-op, operating room, post-op, acute/chronic pain, intensive care unit. as anesthesiologist specialties include: cardiac, thoracic, neuro, general surgery, obstetrics, gynecology, urology, surgical intensive care, emergencies, regional anesthesia, transthoracic echocardiography; vascular

C. NAME OF BUSINESS / INSTITUTION <i>California Pacific Medical Center</i>		JOB TITLE <i>Medical Intern</i>	
ADDRESS STREET, CITY, STATE, ZIP CODE <i>2333 Buchanan Street, San Francisco, CA 94115</i>		DESCRIPTION OF DUTIES PERFORMED <i>Clinical duties caring for patients in the medical wards, medical intensive care unit, cardiac care unit, cardiology, hematology & oncology.</i>	
DATE OF EMPLOYMENT/ATTENDANCE From <i>06/24/2006</i> Month Day Year	HOURS WORKED PER WEEK <i>70</i>	TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
To <i>06/23/2007</i> Month Day Year			
TOTAL TIME WORKED (Year/Month) <i>1 year</i>			
D. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
E. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
F. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			

NAME (Last, First, MI): *Nagpal, Geeta*

SS#: [REDACTED]

Profession: *Physician*



Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

7/11/2011

To Whom It May Concern:

This certifies that Geeta Nagpal, M.D., a 2006 graduate of Univ. of California, San Francisco, School of Med., has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 240549 was issued to Dr. Nagpal on 05/06/2009. The license status is: Active. The expiration date is 6/12/2012.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

SEAL


Staff Member, Board of Registration in Medicine

Michael Cox



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

(CFR)

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 NAGPAL, GEETA	2 DATE OF BIRTH [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 036 Profession Name Profession Code	
6 MAIDEN OR GIVEN SURNAME NAGPAL	7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable)	
8. ISSUANCE DATE		

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 36 months of postgraduate clinical training in Anesthesiology

(Name of Specialty Program)

from 7/1/2007 to 6/30/2010 at the following hospital

Hospital: Brigham and Women's

Number and Street: 75 Francis Street

City, State and Zip Code: Boston MA 02115

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

- the ACCME
- the AOA
- the CFPC, RCPC or FMLAC (Canadian Programs)
- not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Robert Lelowski

Signature of Postgraduate Clinical Training Program Director: [REDACTED]

Date of this Certification: 7/15/2011

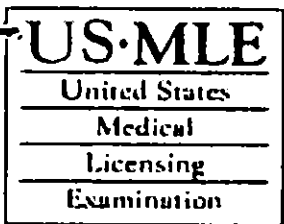
University/Hospital
SEAL

Telephone No: 617-732-8218

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

C

Nagpal, Geeta



United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4041

RECEIVED ELECTRONICALLY

Date : 08/05/2011

Recipient:

Illinois Department of Financial and Professional Regulation
ATTN: Sandy Dunn, Manager of Med Licensure
320 W Washington Street
3rd Floor
Springfield, IL 62786

Examinee: Nagpal, Geeta
Alt Name(s):

Examinee ID#: [REDACTED]
Date of Birth: [REDACTED]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
04/10/2004	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
02/27/2006	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
02/21/2006	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
CALIFORNIA 11/14/2006	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

RECEIVED
AUG 08 2011
IDFPR - MEDICAL UNIT

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APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.


1. NAME LAST FIRST MIDDLE NAGPAL GEETA	2. DATE OF BIRTH _____ <small>Month Day Year</small>	3. SOCIAL SECURITY NUMBER _____
4. ADDRESS STREET, CITY, STATE, ZIP CODE _____	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME NAGPAL	PHYSICIAN <small>Profession Name</small>	036 <small>Profession Code</small>

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY
 Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was owned or operated by the medical college from which he graduated, sign the certification below.

CERTIFICATION

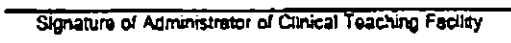
I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility owned or operated by the medical college from which he graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

<p style="text-align: center;">  <small>Signature of Dean of Medical College</small> M. Papadakis, MD <small>Type Name of Dean of Medical College</small> 8/01/2011 <small>Date</small> </p>	<p style="text-align: center;"> University of California, San Francisco <small>Name of Medical College</small> 513 Parnassus Ave., S-245 <small>Street Address</small> San Francisco, CA 94143-0454 <small>City State Zip Code</small> </p>
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B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was formally affiliated or contracted with the medical college from which he graduated, sign the certification below. Further, you must submit a copy of the affiliation agreement between the hospital and the medical college which conferred the degree and a copy of an evaluation form for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility formally affiliated or contracted with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

<p style="text-align: center;">  <small>Signature of Administrator of Clinical Teaching Facility</small> <small>Type Name of Administrator of Clinical Teaching Facility</small> <small>Date</small> </p>	<p style="text-align: center;"> <small>Name of Clinical Teaching Facility</small> <small>Street Address</small> <small>City State Zip Code</small> </p>
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