

**SUPPLEMENTAL QUALIFICATIONS STATEMENT FOR
Medical Officer/Dental Officer Positions**

(Please complete this form and attach to your application.)

Name (Last, First, Middle) _____

Address (Number, Street, City, State, Zip Code) _____

Basic Professional Training (Name and Location of School) _____

Type of Degree: MD DO DDS Date Received _____

If your degree was received in a school outside of the U.S., have you passed the examination given by the Education Council for Foreign Medical Graduates? YES NO

Name and Location of School _____ Date Received _____

INTERNSHIP:

Type of Internship and Specialty _____

Name and Location of Hospital (City and State) _____

Name of Chief of Service or Program Director _____

Dates Attended (Month/Year) from _____ to _____

Date Certificate Received _____

RESIDENCY TRAINING AND FELLOWSHIP:

Name of Specialty _____

Name and Location of Hospital (City and State) _____

Name of Chief of Service or Program Director _____

Dates Attended (Month/Year) from _____ to _____

Date Certificate Received _____

OTHER GRADUATE EDUCATION:

Major field of study or program _____

Name and Location of Institute (City and State) _____

Certificate, Diploma, or Degree Received and Date _____

Dates Attended (Month/Year) from _____ to _____

CERTIFICATION BY A SPECIALTY BOARD:

A: Are you eligible for certification by an American Specialty Board? YES NO

B: Are you board certified? YES NO

If your answer to A or B is "Yes," furnish the following:

Name of specialty board: _____

Specialty _____ Date of Certification _____