**IOWA BOARD OF MEDICINE**
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

# POSTGRADUATE TRAINING PROGRAM CERTIFICATION
## (For Resident License Applicants Only)

Applicants who are applying for a resident license must forward this form to the Resident Program Director at your proposed Iowa training program. The Program Director must complete and submit this form to the *Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686*.

**Resident Applicant's Name:** _____
(First, Middle, Last)

**Program Facility/Department:** _____

**Mailing Address:** _____

**City, State, Zip:** _____

**Proposed Training Program(s):**_____
e.g. Family Practice, Internal Medicine. Residents, who have an initial contract to participate in a preliminary year of general training followed by specialized training, e.g. one year of internal medicine followed by three years of dermatology, may participate in both programs under one resident license if the resident's license application specifies a combined program under this section.

**Expected Start Date:** _____ **Expected Date of Completion:** _____

(The expected date of completion will be the expiration date of the license.)

**Is this training program accredited?** Yes ☐ No ☐ If yes, by whom? _____

**Program Director's Name:**_____

**E-Mail:**_____ **Phone:**_____

**Program Coordinator's Name:**_____

**E-Mail:**_____ **Phone:**_____

I, _____, hereby certify that the above-named physician will be employed by this institution for resident training program, provided he/she has been duly licensed as a resident physician by the Iowa Board of Medicine. I further certify that I believe this applicant is qualified to practice as a resident physician in the State of Iowa. I have carefully examined the statements made in this application and believe them to be true in every respect.

I understand that the resident license is a restricted license valid only for practice within the program and department(s) approved by the Board on this application, and valid only for practice under the supervision of a licensed practitioner of medicine and surgery or osteopathic medicine and surgery.

Signature _____ Date _____