Candidate Name: **Proposed Department:**

University of Michigan Health System
Medical Staff Services
Phone: (743) 647-6865

CERTIFICATION OF POSTGRADUATE TRAINING FOR DENTISTS

Applicant's Name (Last, First, Middle, Suffix): _____
Other Name (If applicable): _____
Social Security Number: _____ **Date of Birth:** _____

I hereby release from liability all individuals and organizations that provide information concerning my qualifications for staff appointment and clinical privileges.

Signature of Applicant: _____ **Date:** _____
Upon completion of information, send this form to the Director of Dental/Medical Education where you completed your postgraduate training.

TO BE COMPLETED BY THE DIRECTOR OF POSTGRADUATE EDUCATION PROGRAM

School name: _____
Street address: _____
City, State, Zip code: _____
Country:_____

FAX TO MEDICAL STAFF SERVICES
WITH AN INSTITUTIONAL COVERSHEET
TO 734-936-9757

I certify that _____ has successfully completed postgraduate **clinical training as**

a(n) _____, offered by the institution named above from _____ to _____ in the
(MM/DD/YY) **(MM/DD/YY)**

clinical area of _____

_____ _____
Signature of Director of Dental/Medical Education or Program Director **Date of Signature**

Print Name: _____ **Email Address:** _____
Print name of Director of Dental/Medical Education or Program Director

Phone Number: _____

Please do not use white on this form. Strike through error, correct and initial.