Graduate Medical Education Office
All Certificates will read:

MEDICAL COLLEGE OF GEORGIA
AUGUSTA UNIVERSITY

This form must be completed for each House Staff completing internship, residency, or fellowship training. The certificate ordered will reflect **EXACTLY** what is entered on the lines below.
PLEASE ENSURE THAT THE INFORMATION LISTED BELOW IS ACCURATE AND TYPE OR PRINT LEGIBLY.

1. First Line

First Name: ____________________

Middle Name or Initial: ____________________

Last Name: ____________________

Suffix: ____________________
(Jr./Sr./Other, if applicable)

Title (MD, MBBS, DO, etc.): ____________________
This must reflect title indicted on their medical diploma

2. Second Line

Type of Training: ____________________
Intern/Resident/Fellow

Department/Section: ____________________

3. Third Line

Dates of Training: ____________________
Start Date

____
End Date

Signature of Program Director ____________________ __________
Date

2/15/2023