



DATE:

TO: Kristine Pasciak
Administrator, American Board of Preventive Medicine (ABPM)
111 W Jackson Blvd, Suite 1110
Chicago, IL 60604
phone 312-939-ABPM [2276] fax: 312-939-2218

FROM:

Please complete the following information and return this form to the Board office at the address above or send via facsimile (312) 939-2218 by **July 15**.

VERIFICATION OF RESIDENCY

Applicant Name:

Academic Training (if applicable):

Institution:

Start Date: End: Degree Awarded:

Practicum Year in the specialty area of (please check one):

Aerospace Medicine Occupational Medicine Public Health/General Preventive Medicine

Institution:

Start Date: End: Number of months credited:

I certify that the physician named above has demonstrated satisfactory performance in the residency program. I certify that my residency program was accredited by the Accreditation Council for Graduate Medical Education in the specialty area checked above at the time of the candidate's attendance.

Print name:

Program name:

Program address:

Signature: _____