Osteopathic Medical Board of California

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POSTGRADUATE TRAINING PROGRAM STATUS UPDATE/CHANGE FORM

TRAINEE INFORMATION

Legal Name: Last First Middle Suffix

PROGRAM DIRECTOR TO COMPLETE AOA OR ACGME TRAINING INFORMATION

Program Name:

Dates of Training (mm/dd /yyyy) Start Date _ _/_ _/_ _ _ _ End Date _ _/_ _/_ _ _ _

Status Update/Change Continued Enrollment: Yes☐ No ☐ No Longer Enrolled Effective: _ _/_ _/_ _ _ _

1. Did the trainee resign from the program? If Yes: Date: _ _/_ _/ _ _ _ _ Yes☐ No☐

2. Did the trainee ever take a leave of absence or break from his/her training? Yes☐ No☐
Dates of leave: Start date: _ _/_ _/_ _ _ _ through End date: _ _/ _ _/_ _ _ _

3. Was the trainee ever terminated, dismissed or expelled? **A "Yes" response requires a written explanation that is signed and dated**. Effective Date: _ _/_ _/_ _ _ _ Yes☐ No☐

4. Did the program decline to renew or offer the trainee a postgraduate training program contract for the following year? **A "Yes" response requires a written explanation signed and dated**. Yes☐ No☐

5. Did the trainee transfer to another program? Yes☐ No ☐
If Yes: Location:_____ Date: _ _/_ _/_ _ _ _

6. Is there another reason for the status update or change? **A "Yes" response requires a written explanation signed and dated.** Yes ☐ No☐

PROGRAM DIRECTOR SIGNATURE

SIGNATURE OF PROGRAM DIRECTOR :_____
(Sign Full Name in the Presence of Notary Public)

A notary public or other officer completing this certificate verifies only the identity of the individual who signs the document to

State of _____
County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20 _____,

By, _____ proved to me on the basis of satisfactory evidence to be
(Print Program Director's Name)
the person who appeared before me.

_____
(Signature of Notary Public)

PROGRAM OR NOTARY SEAL