



Secretary of State
Office of Professional Regulation

**OSTEOPATHIC PHYSICIAN
Internship Training Affidavit**

This form must be completed by an authorized staff member of the hospital where you served your internship.

Name of Applicant: _____

I hereby certify that _____,

a graduate of _____, has satisfactory completed _____

year(s) internship in the _____

hospital.

Said internship began on _____ and ended on _____.

I further certify that the hospital named above is approved for Intern Training by the Bureau of Hospitals of the American Osteopathic Association or the American Medical Association.

Print Name of Authorized Person

(Affix Seal Here)

Signature of Authorized Person

Date