POSTGRADUATE TRAINING VERIFICATION FOR A LIMITED LICENSE TO PARTICIPATE IN A POSTGRADUATE TRAINING PROGRAM

Part of State Form 50318 (R10 / 1-21)

This form is to be completed by the Hospital / Institution Chairperson / Department Head and submitted directly to the address below:

INDIANA BOARD OF PODIATRIC MEDICINE
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.in.gov

This is to certify that _____ has been granted an appointment to serve at

_____ in the Department of _____

located at (*address*) _____

This appointment is for the month and year beginning _____ and ending _____.

Printed name of Hospital Chairman / Department Head	Title
Signature of Hospital Chairman / Department Head	Date (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)	
Telephone number ( )	E-mail address