TEMPORARY POSTGRADUATE TRAINING PERMIT

FORM D
CHANGE OF PROGRAM DIRECTOR

I hereby certify that effective _____, I have been appointed as
(Date)

Program Director for the _____ and the
(Name of Postgraduate Training Program)

attached list of temporary post graduate permit holders. I further certify that these permit holders will limit their practice to such acts as may be prescribed by or incidental to the training program, that they may train only under the supervision of physicians responsible for supervision as part of the training program and may practice in facilities affiliated with the program only if such practice is part of the training program for which the permit is granted. I understand that I **must report to the Georgia Composite Medical Board within 15-days a permit holder's withdrawal or termination from or completion of a postgraduate training program, any disciplinary action regarding quality of care and/or ability to practice with reasonable skill and safety, or any permit holder who has left the program for any length of time in excess of two weeks.**

I hold an active license to practice medicine in the State of Georgia. My license number is _____.

Please type or print: _____
Program Director's Name

Signature: _____ Date:_____

Sworn to and subscribed before me this _____ day of _____, _____.

Signature of Notary Public_____

My Commission Expires: