

CERTIFICATION AND RELEASE

I hereby certify that the information provided in the Postdoctoral Training Application is true and correct to the best of my knowledge. Furthermore, I understand that false and/or omitted relevant information in any part of the application will invalidate this application and will result in immediate rejection of the application or dismissal from the graduate medical education program, if admitted.

I hereby release from any and all liability the West Virginia School of Osteopathic Medicine (WVSOM) and/or its designee and any medical school, hospital, medical clinic, medical society, medical licensing board, malpractice carrier, physician's office and/or other institution with whom I have been or am currently associated, and consent that they may provide WVSOM with any verbal or written information in their possession regarding my professional qualifications, competence, personal character and ethics.

Signature of Applicant

Date

PLEASE INDICATE AFFILIATED HOSPITAL(S) AND PROGRAMS TO WHICH YOU WOULD LIKE TO APPLY:

Family Practice Residency

- ~ Charleston Area Medical Center
- ~ Greenbrier Valley Medical Center
- ~ Logan Regional Medical Center
- ~ Ohio Valley Medical Center
- ~ The Toledo Hospital
- ~ United Hospital Center
- ~ Wheeling Hospital

Internal Medicine Residency

- ~ Charleston Area Medical Center
- ~ Ohio Valley Medical Center
- ~ West Virginia University Hospitals, Inc.

Emergency Medicine Residency

- ~ Ohio Valley Medical Center

Internal Medicine/Emergency Medicine Combined Residency

- ~ Ohio Valley Medical Center

Pediatrics Residency

- ~ Charleston Area Medical Center