KANSAS OSTEOPATHIC SERVICE SCHOLARSHIP
RESIDENCY VERIFICATION FORM

SECTION A: Name and Address

Name: _____
Last First Initial Maiden Name

Home Address:

_____
Street City State Zip

Permanent Address:

_____
Street City State Zip

Telephone: Email address:

_____
Home or Work

SECTION B: Internship/Residency **(If internship/residency is complete, go to Section C.)**

Location:_____
Name of Facility Phone number

_____-_____
Address City State Zip

Beginning Date: _____ Ending Date: _____

Will you be at the above location for the next 12 months? Yes____ No____
If no, please identify new location and date of arrival.

_____ _____
(Location & address) (Date)

Type of internship/residency program in which you are enrolled: (check one)

_____ Family Practice
_____ Family Medicine
_____ Geriatric Medicine
_____ Internal Medicine
_____ Emergency Medicine
_____ Pediatrics
_____ Obstetrics & Gynecology

Date available for practice in Kansas: _____

(Continue on back)

SECTION C: Practice Verification

If you have completed your training, but have not yet established a practice, please estimate where and when you anticipate establishing a practice in Kansas.

Location: _____ _____
Name of clinic, hospital, etc — Phone Number

_____ _____
Address — County

_____
City — State — Zip

Start Date: _____ Type of Practice: _____
(Example: Family Practice, Pediatrics)

SECTION D: Official Signatures of Verification

An official at a hospital or clinic where you are serving your residency/internship or associated with your medical practice must complete this section.

I hereby certify that _____ is presently serving in:
(Name)

(Check one)

□ **Internship** _____
Type of program
Beginning Date: _____ Ending Date: _____

□ **Residency** _____
Type of program
Beginning Date: _____ Ending Date: _____

□ **Medical Practice** _____
Type of program
Beginning Date: _____
Approximate average hours worked per week at this facility: _____

Signature of Hospital Administrator or other official:

_____
Name and Title (print or type)
Date: _____

Name and address of facility:

_____
_____
_____

Thank you for furnishing this information: Please return this form to:

Kansas Board of Regents
Osteopathic Medical Service Program
1000 SW Jackson St, Suite 520
Topeka, KS 66612-1368
(785) 430-4255
loldhamburns@ksbor.org