



Verification of Oral Medicine Practice: Candidates Name

date: _____ *from::* _____
to: _____ *telephone:* _____
email: _____ *fax:* _____

To Whom It May Concern:

The above referenced applicant has applied for American Board of Oral Medicine Part B exam eligibility. In order to process Dr. XXXX's application we need verification that he/she has been engaged in the clinical practice of Oral Medicine for the last eighteen (18) months. Please find attached Verification Questionnaire and a signed release form from the applicant.

If you would like to discuss matters relative to Dr. XXXX's application, please feel free to contact the ABOM at (XXX)-XXX-XXXX.

Thank you for your time and assistance with completing this verification attestation, and we look forward to your earliest response.

Sincerely,

XXXXXXX

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QUESTIONNAIRE

1. During what time frame was the applicant enrolled in an Oral Medicine training program?

From/To (mm/dd/yy)

2. Was the training completed? Yes No

3. Which settings have you observed the applicant in?

Office Training Program Hospital Other: _____

4. With what frequency did you observe the applicant?

Daily Monthly Weekly Other: _____

5. Please state the name of the Organization & your Title during the time you observed the applicant:
_____; please also state the applicant's Title or Position during the
time: _____

6. Have you been or are you related to the applicant as family ?

Yes, please state relationship: _____ No

7. I hereby verify that the above candidate has practiced Oral Medicine for the past 18 months.

Yes No

Signature:

Title:

Date: