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 eligibilty. 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

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: