



Pennsylvania
Department of State

BOARDS OF MEDICINE AND OSTEOPATHIC MEDICINE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
COMMONWEALTH OF PENNSYLVANIA

**AUTHORIZATION OF ADDITIONAL HOSPITAL ADMINISTRATORS TO ACT ON
BEHALF OF GRADUATE MEDICAL TRAINEE APPLICANT OR LICENSEE**

APPLICANT/LICENSEE NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____ LAST 4 DIGITS OF SSN: _____
MM/DD/YYYY MARK N/A IF NOT APPLICABLE

APPLICATION NUMBER: AA000 LICENSE NUMBER: _____
MARK N/A IF NOT APPLICABLE

HOSPITAL NAME: _____

HOSPITAL NUMBER: HS

AUTHORIZATION STATEMENT

I hereby authorize the below named individual(s) to act as authorized third party. They may speak on my behalf after providing verification of my full name, date of birth, and last four digits of my social security number (SSN) if applicable.

NAME(S) OF AUTHORIZED THIRD PARTY

1. _____
2. _____
3. _____

VERIFICATION

I verify that the contents of this authorization are true and correct to the best of my knowledge, information, and belief. I understand that any false statements made are subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsifications to authorities). I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa.C.S. § 4911 (relating to tampering with public records or information).

PRINTED NAME OF APPLICANT/LICENSEE

SIGNATURE OF APPLICANT/LICENSEE

DATE