



**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 ____ Internal Medicine ____ Pediatrics
____ Family Medicine ____ Emergency Medicine ____ Obstetrics & Gynecology
____ Geriatric Medicine

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 completed form:
•Upload to sfa.kansasregents.org OR
•Email loldhamburns@ksbor.org OR
•Fax 785.430.4233 OR
•Mail to Osteopathic Scholarship Program 1000 SW Jackson St,
Suite 520 Topeka KS 66612-1368