



Educational Loans
Physicians Caring for Texans

Verification of Internship/Residency/ Fellowship

This is to certify that _____
Name

is an Intern
 Resident
 Fellow

in _____
Field of medicine

at the _____
Name of hospital

beginning _____ and ending _____
Date Date

Name of Authorized Official

Address

Authorized Official's Signature

City, State, Zip

Title

Telephone

Date