# CERTIFICATE OF COMPETENCY - OSTEOPATHIC PHYSICIAN & SURGEON

Access this form via website at: **cca.hawaii.gov/pvl**

**INSTRUCTIONS TO APPLICANT**: Complete information ABOVE dotted line, then send a form to **two** (2) osteopathic or allopathic physicians who will attest to your competence.

TO: (Fill in name and address of person who will attest to your abilities)

_____

_____

_____

RE: _____
(Print Name of Applicant)

I am applying to the Hawaii Medical Board for a license to practice osteopathic medicine and surgery in Hawaii. It is required that I have two osteopathic or allopathic physicians attest to my competency.

Please complete the following form and mail it to:

Hawaii Medical Board
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

OR

Deliver to office location at:

335 Merchant Street, Room 301
Honolulu, HI 96813

Phone No.: (808) 586-3000

_____ Applicant's Signature

_____ Date

* * * *

Print Name of Applicant: _____ Date: _____

7. Check one in each category:
   a. Professional ability and competency . . . . . ☐ EXCELLENT ☐ GOOD ☐ AVERAGE ☐ POOR
   b. Attention to duties and reliability . . . . . ☐ EXCELLENT ☐ GOOD ☐ AVERAGE ☐ POOR

8. If you have any additional information with respect to this applicant's professional ability or conduct, state here:

_____

_____

_____

_____

_____

List all state licenses held by you:

| Name of State | License No. |
|---|---|
| | |
| | |
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| | |
| | |

Completed by:

_____
Print Name

_____
Signature

_____
Date

Address:

_____

_____

_____

Print Form

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.