Postgraduate Medical Education
UNIVERSITY OF TORONTO

LETTER OF AUTHORIZATION FOR PGME CERTIFICATE PICKUP

Date: _____

To: Postgraduate Medical Education Office
Faculty of Medicine, University of Toronto
500 University Avenue, Suite 602
Toronto, Ontario M5G 1V7

I, _____ authorize
Your name here – please print

_____ to pick up the
Name of person authorized to pick up certificate on my behalf – please print (named individual will require suitable identification)

PGME certificate on my behalf. The details are as follows:

Department: _____

Program: _____

Date of Program Completion: _____

UofT Student Number / Date of Birth: _____

Sincerely,

_____
Signature of PGME trainee (original signature required)

Please note that the <u>original</u> signed letter of authorization must accompany the person designated to pick up your certificate (faxed or otherwise electronically sent copies are not acceptable).