

**COMMONWEALTH OF MASSACHUSETTS**

**BOARD OF REGISTRATION IN MEDICINE  
560 HARRISON AVENUE  
BOSTON, MASSACHUSETTS 02118**

**Fifth Pathway Verification**

Applicant Instructions: Complete Section 1 and Section 2 of this form then send the form to the director of your 5<sup>th</sup> Pathway Program. Please request the Program director or designated official to complete Section 3 of this form and return it directly to the Board at the above listed address.

**Section 1: Applicant Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Section 2: INSTRUCTIONS TO THE PROGRAM DIRECTOR OR DESIGNATED OFFICIAL**

**Please complete Section 3 of this form and attach a recommendation letter from the Program Director and forward this information directly to this Board to the following address:**

Board Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Section 3: Medical School Verification**

Medical School Name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Applicant's Attendance Dates: From \_\_\_\_\_ To \_\_\_\_\_ Program Completion Date: \_\_\_\_\_  
*(Indicate N/A if not applicable)*

***I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.***

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE**