

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

200 Harvard Mill Square, Suite 330

Wakefield, MA 01880

Fifth Pathway Verification

Applicant Instructions: Complete Section 1 and Section 2 of this form then send the form to the director of your 5th 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