

FORM E-1 Return to: Board of Registration in Medicine, 200 Harvard Mill Square Suite 330, Wakefield, MA 01880



INTERNATIONAL MEDICAL GRADUATES: COMPLETE FORM E-1 IF YOU HAVE COMPLETED ANY REQUIRED, OR MORE THAN THREE (3) MONTHS OF ELECTIVE, MEDICAL SCHOOL CLINICAL STUDY AS A PART OF THE TWO (2) YEAR MEDICAL SCHOOL CLINICAL STUDY REQUIREMENT IF A) THERE WAS NO ONSITE SUPERVISION AND EVALUATION BY THE MEDICAL SCHOOL, AND B) THE TRAINING FACILITY WAS UNDER THE DIRECT SUPERVISION OF THE MEDICAL SCHOOL FACULTY.

INSTRUCTIONS: Please complete the following information regarding all of the applicant's clinical training and include school transcripts with this form.

Name of Applicant _____ Training Institution: _____

Area of Study	Name of Program Director	Name of Supervisor	Name and Address of Hospital	Was This Hospital the Primary Teaching Hospital for Your Medical School? (YES/NO)	Was This Hospital an Affiliated Teaching Hospital for your Medical School at the Time the Applicant Completed Clerkships There? (YES/NO) If YES, See Instructions.
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
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				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Signature of Dean or Designated Official: _____

SCHOOL SEAL

Name (please print): _____

Title: _____

Date: _____

FORM E-1 Continued

Name of Applicant: _____

Area of Study	Name of Program Director	Name of Supervisor	Name and Address of Hospital	Was This Hospital the Primary Teaching Hospital for Your Medical School? (YES/NO)	Was This Hospital an Affiliated Teaching Hospital for your Medical School at the Time the Applicant Completed Clerkships There? (YES/NO) If YES, See Instructions.
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
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