

Board of Registration in Medicine  
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880  
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

**MEDICAL EDUCATION VERIFICATION**

**APPLICANT INSTRUCTIONS:** Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Print or Type Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
(Last name) (First Name) (Middle Initial)

Other Name(s) \_\_\_\_\_  
(Please type or print name(s))

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State or Province: \_\_\_\_\_

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

**APPLICANT'S EDUCATIONAL HISTORY**

If name of institution was different from the above named institution when applicant attended, please enter name below:

\_\_\_\_\_

**Premedical Education:** Does your school have a premedical school education requirement?  Yes  No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: \_\_\_\_\_

Undergraduate School Address: \_\_\_\_\_

**Full License Application**

**Enrollment and Participation:** Our records indicate that

(type or print the applicant's name): (Last name) (First name) (Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

<b><u>ATTENDANCE DATES:</u></b>	<b><u>FROM</u></b>	<b><u>TO</u></b>	<b><u>FROM</u></b>	<b><u>TO</u></b>
	____/____/____	____/____/____	____/____/____	____/____/____
	____/____/____	____/____/____	____/____/____	____/____/____
	____/____/____	____/____/____	____/____/____	____/____/____

The applicant attended \_\_\_\_\_ total weeks or \_\_\_\_\_ total months (must be included) **of not less than 32 weeks in each academic year of continuing on-campus education.**

**check one**  was awarded a degree in \_\_\_\_\_ on (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 was **NOT** awarded degree. Please explain reason(s) \_\_\_\_\_

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b><u>YES</u></b>        | <b><u>NO</u></b>         |
| 1. Did the applicant take any leaves of absence or breaks from his/her medical education? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Was the applicant ever placed on probation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Was the applicant ever disciplined or under investigation?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Were any negative reports ever filed by instructors regarding the applicant?           | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS: \_\_\_\_\_

**AFFIX INSTITUTIONAL SEAL HERE**

**(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.**

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

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

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

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

**This form will not be accepted unless it is stamped with the institutional seal or notarized.**