

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

MEDICAL EDUCATION VERIFICATION – FORM A

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. **Please Note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

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 Form A and complete Form B if the above named applicant has not been awarded a degree. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

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: _____

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):

ATTENDANCE DATES:

FROM	TO	FROM	TO
____/____/____	____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____
____/____/____	____/____/____	____/____/____	____/____/____

The applicant attended _____ total weeks (**must be included**) of continuing on-campus education, not less than 32 weeks in each academic year

check one was awarded a degree in _____ on (month/day/year) ____/____/____

will be awarded on ____/____/____ (**Form B must also be completed and returned directly to the Board**)

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.**

- | | YES | NO |
|------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Did the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".) | <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.