

Commonwealth of Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 Wakefield, MA 01880 - (781) 876-8210 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: _____

Temporary 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):

ATTENDANCE DATES: FROM TO FROM TO

____/____/____ ____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____ ____/____/____

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.**

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 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.