Massachusetts
Board of Registration in Medicine
Substantial Equivalency Clerkship
Verification Form

Please ask the Dean or Designated Official of the Medical School to fill out the attached form. This form must be stamped with the institutional seal or notarized.

The Dean or Designated Official may submit the document electronically to the Massachusetts Board of Registration in Medicine as follows:

- Use a web browser to navigate to the following URL:

- Enter the following fields exactly as they appear below:

Document Upload Code:

Applicant Last Name:

- Click the "Proceed" button
- Upload the document(s) by clicking or dragging them onto the upload

rectangular area.

Please note that once a document has been uploaded it may not be deleted.

Commonwealth of Massachusetts Board of Registration in Medicine
178 Albion Street, Suite 330 – Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

International Medical School - Substantial Equivalency Determination Clinical Clerkship Verification Form

APPLICANT INSTRUCTIONS: If you completed more than three (3) months of clinical clerkships off-site of the primary teaching hospital of your medical school, please complete the top section and provide this Form to your medical school for completion. This Form is required to assist the Board in its determination whether an applicant's course of medical school education is substantially equivalent, in its entirety, to a U.S. medical school graduate's education.

Applicant Print Name: _____ Date of Birth: _____ _____ _____

Name of Medical School: _____

MEDICAL SCHOOL SECTION – VERIFICATION OF CLINICAL CLERKSHIPS

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL:

- Please complete this form listing all clerkships completed by applicant.
- This form must be stamped with the institutional seal or notarized on the second page.
- Please submit the form by following the instructions on the cover page.

Clerkship Subject	# of Weeks	Facility Name	Facility City/State	Was this facility the medical school's Primary Teaching Facility?	Did the Clerkship Supervisor hold a faculty appointment at the medical school?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

(Continued on next page)

APPLICANT'S NAME: _____

Clerkship Subject	# of Weeks	Facility Name	Facility City/State	Was this facility the medical school's Primary Teaching Facility?	Did the Clerkship Supervisor hold a faculty appointment at the medical school?
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO
				☐ YES ☐ NO	☐ YES ☐ NO

CERTIFICATION AND SEAL

SEAL / NOTARY
If the institution does not have a seal, this form must be notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Signature: _____

Print Name: _____

Title: _____

Date: _____ _____ _____ Telephone: _____

E-mail address: _____

SUBMIT THE COMPLETED CERTIFICATION ELECTRONICALLY USING THE INSTRUCTIONS ON THE COVER PAGE.