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

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Primary source verification must be received from ALL medical schools of attendance. Please complete the below Waiver and forward this form to your medical school(s). **Note:** Fourth year medical students must include the letter to the medical school registrar and Form B. This form does not need to be completed if you are submitting verification of your medical education through FCVS or if you ever held a Limited License in Massachusetts.

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 Name: _____

Print Other Name(s): _____

Name of Medical School: _____

Address: _____ City: _____ State/Province: _____

MEDICAL SCHOOL SECTION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL:

- Please complete all sections of Form A. For fourth year medical students, please complete Form B after the student completes the degree requirements.
- **International medical schools** must include a copy of the official transcript (indicating courses taken, dates and hours of attendance, scores, grades, or evaluations) and diploma.
- This form must be stamped with the institutional seal or notarized on the second page.
- Return form to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

Name of Medical School:

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

Premedical Education:

Does your school have a premedical school education requirement? ☐ Yes ☐ No

If "yes", indicate where the applicant completed premedical school below:

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

(Continued on next page)

Enrollment and Participation:

Our records indicate that: _____
(Print the applicant's name): Last name First name Middle Initial

attended our medical school for a total of _____ **weeks** of continuous medical education on the following dates

from _____ _____ _____ to _____ _____ _____.
month/day/year month/day/year

Degree Earned:

This applicant: *(Check one of the following)*

☐ **was awarded** the degree of _____ on _____ _____ _____
month/day/year

☐ **is expected to be awarded** the degree of _____ on _____ _____ _____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because: _____

Unusual Circumstances:

The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **Please provide an explanation for any "YES" answers in the space below or enclose a separate page.**

QUESTIONS	**YES**	**NO**
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, M.D./Ph.D. program) or for any "personal reasons"?	☐	☐
2. Was the applicant ever placed on probation or remediation?	☐	☐
3. Was the applicant ever disciplined or under investigation?	☐	☐
4. Were any negative reports ever filed by instructors regarding the applicant?	☐	☐

Explanation for any "YES" answers: _____

_____

_____

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: _____