**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**](http://www.mass.gov/massmedboard)

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| **Limited License Application - 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: |

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| **MEDICAL SCHOOL SECTION – VERIFICATION OF CLINICAL CLERKSHIPS** | | | | | |
| **INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL:**   * Please complete the form listing all clerkships completed by applicant and provide copies of the clerkship evaluations. * This form must be stamped with the institutional seal or notarized on the second page. * Return form and the clerkship evaluations to the applicant in a sealed envelope or forward directly to the Board. Please sign or stamp across the seal on the envelope. | | | | | |
| **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 |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL OR FORWARD DIRECTLY TO THE BOARD.** | | | | | | |