**Board of Registration in Medicine**

**200 Harvard Mill Square, Suite 330**

**Wakefield, MA 01880**

**Telephone: (781) 876-8210 Fax: (781) 876-8383**

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

**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: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name (Please type or print):

 (Last Name) (First Name) (Middle Initial)

Other Name(s) (Please type or print.):

Name of Medical School:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State or Province:

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

**Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. 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

(Print the applicant’s name): (Last name) (First name) (Middle Initial)

attended our medical school for a total of \_\_\_\_\_\_weeks (must be included) of continuous medical education on the

following dates from \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_.

 month/day/year month/day/year

**This applicant:**

*Check one:* □ **was awarded the** degree of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 month/day/year

* **will 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. All questions must be answered. **If you answer “YES” to any of the questions below, please enclose an explanation.**

 **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, participation in an 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? □ □

**Please provide a detailed explanation for any of the above questions**

|  |  |
| --- | --- |
| **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: (\_\_\_\_\_)                                   E-mail address:                                                                                       |

**This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.**