



**Medical School Verification (UA Form #2)**

Applicant: Complete this form as instructed in the left sidebar.

Dean or Designated Med School Official: Complete as instructed in the left sidebar.

**Applicant:**

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Use the medical board directory located at <http://www.fsmb.org/policy/contacts> to ensure you list the correct name/address.

**Section 1: Applicant Information**

Last name: \_\_\_\_\_ Suffix: \_\_\_\_\_

First name: \_\_\_\_\_

Middle name: \_\_\_\_\_

Name if different when diploma awarded: \_\_\_\_\_

Name of medical school: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Social Security number\*: \_\_\_\_\_

*\*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Waiver for Release of Information:** I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Applicant signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dean or Designated Official:**

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the state board listed in Section 1.

**DO NOT MAIL THIS FORM TO FCVS/FSMB.**

If transcripts are not in English, an original, certified, and official English translation is required.

**Section 2: Medical School Verification**

Medical school name: \_\_\_\_\_

School name if different when the above applicant attended: \_\_\_\_\_

Medical school address (including city, state or province, zip code, and country as applicable):  
\_\_\_\_\_  
\_\_\_\_\_

Hours of undergraduate education required for admission into your school: \_\_\_\_\_

Total weeks of education applicant attended your school: \_\_\_\_\_

Applicant's attendance dates: From \_\_\_\_\_ to \_\_\_\_\_

Graduation date: \_\_\_\_\_ Degree: \_\_\_\_\_  
(indicate N/A if not applicable) (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

**Applicant Name:** \_\_\_\_\_

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes  No

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
<input type="checkbox"/> Personal/Family	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Academic remediation	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Financial	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in joint degree program (e.g., MD/PhD)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Participation in non-research special study (e.g., fellowship, international experience)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes  No

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
<input type="checkbox"/> Academic probation	_____	_____
<input type="checkbox"/> Probation for unprofessional conduct/behavioral reasons	_____	_____
<input type="checkbox"/> Probation for other reason(s) (please specify):	_____	_____

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes  No

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes  No

If yes, please attach documentation/information of the nature of the limitations or special requirements.

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Email: \_\_\_\_\_

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)