

PENNSYLVANIA STATE BOARD OF MEDICINE

VERIFICATION OF MEDICAL EDUCATION  
(For Graduates of American/Canadian Medical Schools)

SECTION 1 – TO BE COMPLETED BY APPLICANT

<b>NAME:</b>	Last	First	Middle
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<b>NAME OF MEDICAL SCHOOL:</b>	
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<b>LOCATION:</b>	
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Submit the verification of medical education form to your medical school and request the school return the completed form directly to the Board in an official school envelope.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL

<b>NAME OF MEDICAL SCHOOL:</b>	
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<b>NAME OF MEDICAL STUDENT:</b>	Last	First	Middle
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<b>DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:</b>	Month	Day	Year
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<b>DATE OF GRADUATION:</b>	Month	Day	Year
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I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

<b>SIGNATURE OF DEAN/REGISTRAR:</b>	
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<b>DATE:</b>	Month	Day	Year
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Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

(Seal of School)

**DO NOT RETURN THIS FORM  
TO THE APPLICANT**

**Regular Mailing Address**  
STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400/717-787-2381

**Courier Delivery Address**  
STATE BOARD OF MEDICINE  
2601 NORTH THIRD STREET  
HARRISBURG, PA 17110