## PENNSYLVANIA STATE BOARD OF MEDICINE

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

### SECTION 1 – TO BE COMPLETED BY APPLICANT

<table>
<thead>
<tr>
<th>NAME:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

**NAME OF MEDICAL SCHOOL:**

**LOCATION:**

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

<table>
<thead>
<tr>
<th>NAME OF MEDICAL SCHOOL:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF MEDICAL STUDENT:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

**DATE STUDENT BEGAN TO ATTEND THIS MEDICAL SCHOOL:**

**DATE OF GRADUATION:**

I CERTIFY THAT ALL OF THE INFORMATION LISTED ABOVE IS CORRECT

<table>
<thead>
<tr>
<th>SIGNATURE OF DEAN/REGISTRAR:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE:</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

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

(Seal of School)

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**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