



Verification of Medical Education MD/DO/DPM Licensure

Revised 10/2017

INSTRUCTIONS TO APPLICANT: Complete UPPER portion of form and send directly to the Dean of the medical, osteopathic, or podiatric school. School is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD. The Dean shall also include a Dean's Letter of Recommendation with narrative comments concerning performance as a medical student.

Last Name _____ First Name _____ Middle Name _____

Other Names you have been known by _____ Date of Birth (mm/dd/yy) _____ Last 4 Digits of Social Security Number _____ Attendance FROM (mm/dd/yy) _____ Attendance TO (mm/dd/yy) _____

I authorize the release of any information, favorable or otherwise regarding myself to the Oregon Medical Board. By signing this document, I release the program and its representatives of liability for providing information to the Board.

Signature: _____ Date _____

INSTRUCTIONS TO SCHOOL: Please complete this form, sign and return it to the Board at the address below in an institution envelope. Please also include a Dean's Letter of Recommendation, written during medical school, to include narrative comments concerning performance as a medical student. Faxed responses will NOT be accepted.

Name of Applicant (First, Middle, Last) _____ Date of Degree (mm/dd/yy) _____ Degree Obtained: MD DO DPM

YES NO Was school accredited by the Liaison Committee of Medical Education, the American Osteopathic Association, or the Committee on the Accreditation of the Canadian Medical Schools at the time the applicant graduated?

YES NO If no, did the applicant complete all courses by physical on-site attendance?

Dates of Attendance (Show month/day/year for all dates)		FROM (mm/dd/yy)	TO (mm/dd/yy)		FROM (mm/dd/yy)	TO (mm/dd/yy)
	1 st year			5 th year		
	2 nd year			6 th year		
	3 rd year			7 th year		
	4 th year			8 th year		

TRANSFER STUDENT		
FROM (mm/dd/yy)	TO (mm/dd/yy)	Name of School & Location

LEAVE OF ABSENCE/REPEATED YEAR(S)		
FROM (mm/dd/yy)	TO (mm/dd/yy)	Dates & Reason(s)

Signature of Official _____ Affix School Seal Here

Print Name _____ Date: _____

Name of School at TIME OF GRADUATION _____

Name of School at PRESENT TIME _____

Mailing Street _____

City _____ State _____ Zip _____

Phone Number _____

E-mail _____