Verification of Medical Education
MD/DO/DPM Licensure

Revised 07/2021

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 _____ DOB (mm/dd/yy) _____ Last 4 SSN _____

Institution name at the time of training _____ Dates of Attendance: From (mm/dd/yy) _____ 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)
	1st year			5th year		
	2nd year			6th year		
	3rd year			7th year		
	4th year			8th year		

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

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☐ I understand I am not required to provide the following information, and I ask that the following responses be kept confidential. If requested here, the Board will grant confidentiality for the below information.

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

Signature of Official _____ Affix Seal Here

Print Name _____ Date _____

Title _____

Name of School at GRADUATION _____

Name of School at PRESENT _____

Mailing Street _____

City _____ State _____ Zip _____

Phone _____

E-mail _____