Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: License.wi.gov
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

MEDICAL EDUCATION VERIFICATION FORM

(Not necessary if utilizing FCVS)

APPLICANT: Complete this section and submit directly to your medical school for completion. Form must be returned directly from the medical school to the Department.

Last Name	First Name	MI	Former / Maiden Name(s)

Date of Birth (dd/mm/yyyy)	Social Security Number (voluntary-for school use in locating your records)	Application Number
/ /	- -	

Medical School

Medical School Address (city) (state) (zip code) (country, if not U.S.)

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, please print and sign form.) **Date** / /

MEDICAL SCHOOL: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party*Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

1.	Did this physician attend the medical school noted above?	☐ Yes ☐ No
2.	What were the applicant's dates of enrollment in this medical school? (Provide dates in mm/dd/yyyy format.) Start Date / / End Date / /	☐ Yes ☐ No
3.	Did this physician graduate from this medical school? **If yes, complete fields below. If no, attach explanation on a separate sheet.** Degree Granted _____ Date Degree Granted / /	☐ Yes ☐ No
4.	Did this physician take a leave of absence during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet.**	☐ Yes ☐ No
5.	Did this physician have a record of unexcused absences during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet.**	☐ Yes ☐ No

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6.	Was this physician ever disciplined or under investigation during his/her attendance at this medical school? **If yes, please attach explanation on a separate sheet and indicate if this constitutes adverse formal action.**	☐ Yes ☐ No
7.	Were any special requirements imposed on this physician that were not required of all other students at his/her level of education? **If yes, please attach explanation on a separate sheet.**	☐ Yes ☐ No
8.	Was this physician recommended for post graduate training?	☐ Yes ☐ No

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Dean or Department Head
(If unable to provide a digital signature, please print and sign form.)

Date __/__/____

Printed Name

Phone ___-___-____ Ext_____

Title