MEDICAL EXAMINING BOARD

MEDICAL EDUCATION VERIFICATION FORM
(Not necessary if utilizing FCVS)

APPLICANT: Please forward this form to your medical school.

MEDICAL SCHOOL: The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant's Name:

Social Security #: (for school use to locate your records)

Medical School:

Medical School Address:

1. Did this Physician attend the medical school noted above?  
2. What were the applicant's dates of enrollment in this medical school?  
   Start Date: / /  
   End Date: / /

3. Did this Physician graduate from this medical school?  
   If no, please attach explanation on a separate sheet.
   Degree Granted:  
   Date Degree Granted: / / 

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.

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.

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.

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.

8. Was this Physician recommended for post-graduate training?

Printed Name of Dean: 

Signature:  

Medical School, please return directly to:

DSPS  
Attn: Medical Examining Board  
P.O. Box 8935  
Madison, WI 53708-8935

Or you may fax/email with facility cover sheet/letter to: (608) 251-3036 or DSPSCredMedBD@wisconsin.gov.

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