STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

SCHOOL VERIFICATION FORM

APPLICANT: Please complete Section 1 of this form and forward it to your medical school

THIS FORM, **IN ADDITION TO AN OFFICIAL TRANSCRIPT**, NEED ONLY BE SUBMITTED IF THE APPLICANT EARNED A DEGREE OUTSIDE OF THE UNITED STATES OR CANADA

Section 1:

Name of Applicant: _____

Date of Birth: _____ Year of Graduation _____

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Section 2: **(**This section to be completed by the medical school.)

This office has received an application for Connecticut physician licensure from the individual identified above. In order to complete our review of this individual's credentials for licensure, a verification of educational background is needed. The information below should be completed by the Dean, Registrar or other official authorized to verify educational records at the institution.

Name of Educational Institution: _____

Address of Educational Institution: _____

Dates of Studies FROM:_____ TO:_____

Total number of months of full-time classroom and supervised clinical instruction (record in **MONTHS** only):_____

Did this individual satisfactorily complete the full medical curriculum at this institution? YES: ☐ NO: ☐

Was this individual granted a degree? YES: ☐ NO: ☐ Title of Degree: _____

Date Awarded: _____

At the time of this student's attendance, was this medical school fully licensed and approved, by the appropriate regulatory body of the jurisdiction in which it is located, to award the degree of doctor of medicine or its equivalent? YES: ☐ NO: ☐

_____ _____
Signature **Date**

_____
Title

(SEAL)

Please return this form directly to:

Connecticut Department of Public Health
Physician Licensure
410 Capitol Ave, MS #12 APP
P.O. Box 340308
Hartford, CT 06134