



Bureau of Professional Licensing  
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## CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS

Authority: 1978 PA 368

This form must be submitted directly to this office by the Dean or Registrar of Medical School. If this form is submitted by the applicant, it will not be accepted.

**Section of the Form to be Completed by Applicant:**

Applicant's Name (First, Middle, Last)	Date of Birth
Telephone Number	Email Address
Name of Medical School	
Applicant's Signature	Date

**Remainder of Form to be Completed by the Dean or Registrar of the Medical School:**

Name of Medical School		
Address of Medical School		
City	State	Zip Code

### CERTIFICATION AND SIGNATURE

I certify the applicant named above was/will be granted the degree of \_\_\_\_\_ on \_\_\_\_\_ (Month/Day/Year).

I also certify that the medical education program from which the applicant graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical education program included basic science courses in anatomy; physiology; biochemistry; microbiology; pathology; pharmacology and therapeutics; preventive medicine; and clinical sciences clerkships completed at the hospitals or institutions listed below.

Clinical Sciences	Name and Address of Hospital or Institution	Teaching Hospital	
Internal Medicine		Yes	No
General Surgery		Yes	No
Pediatrics		Yes	No
Obstetrics and Gynecology		Yes	No
Psychiatry		Yes	No

Signature of Dean or Registrar	Date
Print or Type Name of Dean or Registrar	(Seal) If hospital has no seal, please indicate