Bureau of Professional Licensing
PO Box 30670 ● Lansing, MI 48909
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www.michigan.gov/bpl
BPLData@michigan.gov

CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA OR THE DOMINION OF CANADA

Authority: 1978 PA 368

This form must be submitted directly to this office by the dean or registrar of the medical school. If this form is submitted by the applicant, it will not be accepted.

Applicant Information:

Applicant's First Name	Middle Name	Last Name	Date of Birth (MM/DD/YYYY)
Address			
City	State	Zip Code	
Telephone Number	Last 4-digits of Social Security Number		
Name of Medical School			

Type of License Applying for (check appropriate box below):

- ☐ MD Educational Limited License
- ☐ DO Educational Limited License
- ☐ MD Full License
- ☐ DO Full License

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 **has graduated** *or* **is expected to** graduate within 3 months after the date of application for licensure from an approved medical school or osteopathic medical school on _____.
(Month/Day/Year)

_____ _____
Signature of Dean or Registrar Date

_____ (Seal)
Print or Type Name of Dean or Registrar

NOTE: Form will not be accepted if submitted more than 3 months prior to graduation and/or the date of application for licensure.