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# 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 is intended for use by Medical Doctor (MD) license types only.*** 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.

**Applicant Information:**

| Applicant's First Name | Middle Name | Last Name | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|
| Address | | | |
| City | State | Zip Code | |
| Telephone Number | Email Address | | |
| Name of Medical School | | | |
| Type of License Applying for (check appropriate box below): ☐ MD Educational Limited License ☐ MD 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 was / will be granted the Degree of Medical Doctor / Doctor of Medicine/ MD on

______________________________.
(Month/Day/Year)

______________________________
Signature of Dean or Registrar

______________________________
Date

______________________________
Print or Type Name of Dean or Registrar

(Seal)

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



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