New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183
Trenton, New Jersey 08625
(609) 826-7100

Medical Education Verification Form

Applicant's name:_____

Medical school: _____

Medical school address: _____
Street City State Zip Code Country

Telephone number: _____
Include area code

1. Did this physician attend the medical school noted above? ☐ Yes ☐ No

2. What were the applicant's dates of enrollment? _____ to _____
Month/Year Month/Year

3. Did this physician graduate from this medical school? ☐ Yes ☐ No
If "No," please explain below:

_____

_____

4. What was the date of graduation? _____
Month/Year

5. Did this individual take a leave of absence during his/her attendance at this medical school? ☐ Yes ☐ No
If "Yes," what was the reason for the leave of absence?

_____

_____

6. Was this individual on probation during his/her attendance at this medical school? ☐ Yes ☐ No

7. Was this individual ever disciplined or under investigation during his/her attendance at this school? ☐ Yes ☐ No

8. Were any negative reports filed by instructors regarding this individual? ☐ Yes ☐ No

9. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? ☐ Yes ☐ No

Please supply any additional comments or information that the Board should consider prior to determining this applicant's eligibility for licensure.

_____

_____

_____ _____
Print Name of Registar Date

_____
Signature of Registar

Seal of Medical School

Please return **with an official transcript** directly to:

BMEApp@dca.njoag.gov