

AT 1
Verification of AT
Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

For Board Use Only
Program accredited?
Y N
Date verified _____

**VERIFICATION OF PROFESSIONAL EDUCATION FOR
ATHLETIC TRAINER LICENSURE**

Part 1 APPLICANT: Complete Part 1 and send to the institution where you completed your Athletic Trainer program. *(It is not necessary to complete this form if you were certified by the BOC prior to October 1, 2012)*

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ____/____/____ Social Security Number: ____-____-____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: ____/____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2 REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please email this form to: mdh.mbpcredentials@maryland.gov.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

Associate's Degree Certificate Bachelor's Degree Master's Degree Other: _____
(specify)

in _____ The program was accredited by: _____
Educational Program CAATE, CAAHEP, CAHEA, etc.

Printed Name of Authorized Official Name of Institution

Title of Authorized Official Telephone Number Fax Number

Signature of Authorized Official Date

**SEAL
OF THE
INSTITUTION**