

Verification of Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
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For Board Use Only
Program accredited?
____ Y ____ N
Date verified _____

VERIFICATION OF PROFESSIONAL EDUCATION
FOR APPLICANT

Part 1 APPLICANT: Complete Part 1 and send to the institution where you completed your educational program.

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 _____
Educational Program

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