**STATE OF CONNECTICUT**
**DEPARTMENT OF PUBLIC HEALTH**

## SCHOOL VERIFICATION FORM

THIS FORM, **IN ADDITION TO AN OFFICIAL TRANSCRIPT**, NEED ONLY BE SUBMITTED IF THE APPLICANT EARNED A DEGREE **OUTSIDE** OF THE UNITED STATES OR CANADA

**APPLICANT:** Please complete **Section I** of this form and forward it to your medical school.

**SECTION I:**

Name of Applicant: _____

Date of Birth: _____ Year of Graduation _____

**SECTION II TO BE COMPLETED BY EDUCATIONAL INSTITUTION ONLY**

**SECTION II: (This section to be completed by the medical school)**

This office has received an application for Connecticut physician licensure from the individual identified above. In order to complete our review of this individual's credentials for licensure, a verification of educational background is needed. The information below should be completed by the Dean, Registrar or other official authorized to verify educational records at the institution.

Name of Educational Institution: _____

Address of Educational Institution: _____

_____

Dates of Studies From:_____ To:_____

Total number of months of full-time classroom and supervised clinical instruction (record in **MONTHS** only):_____

Did this individual satisfactorily complete the full medical curriculum at this institution? YES☐ NO☐

Was this individual granted a degree? YES☐ NO☐ Title of Degree: _____ Date Awarded: _____

At the time of this student's attendance, was this medical school fully licensed and approved, by the appropriate regulatory body of the jurisdiction in which it is located, to award the degree of doctor of medicine or its equivalent? YES: ☐ NO:☐

_____ _____
***Signature*** ***Date***

_____
***Title***

# SEAL

Please complete this form and return directly to:

Department of Public Health
Homeopathic Physician Licensure
410 Capitol Ave, MS #12 APP
P.O. Box 340308
Hartford, CT 06134-0308