

University of Vermont College of Medicine

Medical Education Verification Release & Document Request Form

Name
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Current Name
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Previous Names

Contact Information
Address: _____ _____ _____
Phone: _____
E-mail: _____

Documents Requested
<input type="checkbox"/> Dean's Letter/ MSPE
<input type="checkbox"/> Letter Verifying Attendance and Graduation Dates
<input type="checkbox"/> Letter Explaining Leave of Absence/Delay of Graduation
<input type="checkbox"/> Certification of Medical School Diploma <i>Note: Please provide a photocopy of your diploma if you graduated before 1996.</i>
<input type="checkbox"/> State Licensing or Credentialing Form <i>Note: Please attach the form needing to be completed</i>
<input type="checkbox"/> Medical School Transcript Signed & Sealed: Yes ___ No ___ <i>Please note that the Student Affairs Office only maintains transcripts for students who graduated in the Class of 2002 and earlier. If you graduated after 2002, we can request a transcript as part of a licensing packet, but for a standard transcript request, please use the Registrar's Office Transcript request form: http://www.uvm.edu/~rqweb/forms/download/transc_reqst.pdf.</i>

Date Request is Due
Please send by: _____ / _____ / _____
Please Note: Do not use this form if you attended summer medical courses while enrolled at another medical school. Contact the UVM Registrar's Office at 802-656-2045. <i>The College of Medicine does not maintain these records.</i>

Enrollment
Years of Attendance: _____ From _____ To _____
Graduated: _____

Personal Information
SSN: _____ -- _____ -- _____
Date of Birth: _____ / _____ / _____

Signature
I authorize the UVM College of Medicine to release the documents and information checked below. Signed: _____ <i>Documents will not be released without a signature.</i>

Destination
<input type="checkbox"/> Send to me at the address above
Send to: _____ Name _____ Company _____ Address _____ City State Zip Code _____ Fax # (if faxed documents are acceptable)
Send to: _____ Name _____ Company _____ Address _____ City State Zip Code _____ Fax # (if faxed documents are acceptable)
If necessary, enclose an address sheet to list additional recipients

Please return this completed form, along with any additional documents needing to be completed, to: Medical Education Verification, Office of Student Affairs, The University of Vermont College of Medicine, The Courtyard at Given, Room N100, 89 Beaumont Avenue, Burlington, VT 05405. **Or FAX to:** (802) 656-9377.