ARIZONA MEDICAL BOARD MEDICAL COLLEGE VERIFICATION FORM

AUTHORIZATION: The Arizona Medical Board requires all applicants for licensure to obtain verification of all medical schools attended. This form must be completed by the medical school **Dean or the Registrar**. This is authorization to release any information in your files of record, favorable or otherwise, **DIRECTLY** to the Arizona Medical Board. Authorization may be sent via mail or fax to 9545 E Doubletree Ranch Road, Scottsdale, AZ 85258 or (480) 551-2704.

First Name: _____ **Last Name:** _____

Signature: _____ **Date:** _____

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1. This is to certify that the applicant listed above was enrolled at (name of college): _____

Located in: City: _____ State: _____

2. The undersigned further certifies that the records of this institution show that the applicant attended this institution: From: _____ (mm/dd/yy) To: _____ (mm/dd/yy)

3. Please check one:

☐ The applicant was granted a medical degree by the above named school on: _____

☐ The applicant withdrew from the above named school on: _____ (mm/dd/yy)

4. Advanced Credits Granted Upon Admission:

Medical School: _____ *Total Credits:* _____ *Dates Attended:* From: _____ To: _____

Name/Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Signature: _____

Date _____ (mm/dd/yy)

Affix Seal of College Here