

# Wisconsin Department of Safety and Professional Services

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## MEDICAL EXAMINING BOARD

### MEDICAL EDUCATION VERIFICATION FORM

(Not necessary if utilizing FCVS)

**APPLICANT:** Please forward this form to your medical school.

**MEDICAL SCHOOL:** The Medical Examining Board requests that you complete this form concerning the following individual:

Applicant's Name:

Social Security #: (for school use to locate your records)    -   -

Medical School:

Medical School Address:

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 1. Did this Physician attend the medical school noted above?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What were the applicant's dates of enrollment in this medical school?   |                          |                          |
| Start Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>  |                          |                          |
| End Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>  |                          |                          |
| 3. Did this Physician graduate from this medical school?<br><b>If no, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| Degree Granted: <input type="text"/>   |                          |                          |
| Date Degree Granted: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>   |                          |                          |
| 4. Did this Physician take a leave of absence during his/her attendance at this medical school?<br><b>If yes, please attach explanation on a separate sheet.</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did this Physician have a record of unexcused absences during his/her attendance at this medical school?<br><b>If yes, please attach explanation on a separate sheet.</b>                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this Physician ever disciplined or under investigation during his/her attendance at this medical school?<br><b>If yes, please attach explanation on a separate sheet.</b>                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were any special requirements imposed on this in Physician that were not required of all other students at his/her level of education?<br><b>If yes, please attach explanation on a separate sheet.</b> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was this Physician recommended for post-graduate training?  | <input type="checkbox"/> | <input type="checkbox"/> |

Printed Name of Dean:

Signature: \_\_\_\_\_ Date   /   /

**Medical School, please return directly to:**

DSPS  
Attn: Medical Examining Board  
P.O. Box 8935  
Madison, WI 53708-8935

**Or you may fax/email with facility cover sheet/letter to:** (608) 261-7083 or [DSPCredMedBD@wisconsin.gov](mailto:DSPCredMedBD@wisconsin.gov).