

MEDICAL EDUCATION
(Page 1 of 2)
(Copy this form for multiple schools)

In applying for a license to practice medicine and surgery, the West Virginia Board of Osteopathy requires this form to be completed by each medical school I attended.

Name: _____

Name if different when diploma awarded: _____

Social Security: _____ DOB: _____

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.
Waiver for release of information: I authorize the Medical School below to provide any and all information pertaining to my medical education at your institution to the WV Board of Osteopathy.

Applicant's Signature

Date

Certificate of Dean, Secretary, or Registrar of Medical College
(Must be completed by a representative of the Medical School)

This is to certify that _____
(Name of Graduate)

has satisfactorily completed _____ years of medical education

at the _____
(Name of Medical College)

located at _____
(Address of Medical College)

The aforesaid graduate received the degree of _____

from this College on _____
(month, day, year)

(Signature)

SEAL OF COLLEGE

(Title)

Return this form to:
West Virginia Board of Osteopathic Medicine
405 Capitol Street – Suite 402
Charleston, WV 25301

Medical School Verification – Page 2 of 2
(Copy this form for multiple schools)

APPLICANT'S NAME: _____

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do the records reflect (an) interruption(s) or extension(s) in his/her medical education? **YES** **NO**

If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extensions(s) and check whether the interruption/extension is approved or unapproved.

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>	<u>Approved</u>	<u>Unapproved</u>
<u>Personal/Family</u>	_____	_____		
<u>Academic remediation</u>	_____	_____		
<u>Health</u>	_____	_____		
<u>Financial</u>	_____	_____		
<u>Participation in joint degree program (e.g. MD/PhD)</u>	_____	_____		
<u>Participation in non-research special study (e.g., Fellowship, International experience)</u>	_____	_____		
<u>Participation in non-degree research</u>	_____	_____		
<u>Other (Please specify):</u>	_____	_____		

2. Do the records reflect that this individual was ever placed on academic or disciplinary probation during his/her medical education? **YES** **NO**

If YES, please select the reason(s) for the probation; indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	<u>From Mo/Yr</u>	<u>To Mo/Yr</u>
<u>Academic Probation</u>	_____	_____
<u>Probation for unprofessional conduct/behavior</u>	_____	_____
<u>Probation for other reason</u>	_____	_____
<u>Please specify reason:</u>	_____	_____

3. Do the records reflect that this individual was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **YES** **NO**

If YES, please provide detailed documentation/information about the circumstances and Outcome(s). _____

4. Do the records reflect that this individual was ever the subject of negative reports or an investigation by the medical school or parent university? **YES** **NO**

If YES, please provide detailed documentation/information about the circumstances and outcome(s). _____

5. Do the records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **YES** **NO**

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements. _____