



Form of Authorization for Release of Information

I, the undersigned, hereby authorize the Federation Credentials Verification Service ("FCVS") to submit to the Educational Commission for Foreign Medical Graduates ("ECFMG"), and authorize ECFMG to collect, verify and maintain, information and copies of documents and records (my "Candidate Information") that may subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges. In addition, I hereby authorize ECFMG to retain my Candidate Information in ECFMG's database for the purposes of (1) addressing any further requests from FCVS for verification and/or source verification of my Candidate Information; (2) responding to any request sent to ECFMG from an authority other than FCVS, as authorized by me, or directly from me, to verify and/or source verify my credentials; and (3) to internally access those portions of my Candidate Information that are not personally identifiable information in order to verify credentials of other persons from time to time.

I request and authorize every person, institution, professional licensing board of any state or country in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency or other third parties and organizations, and their representatives, to release information, records, transcripts and other documents, concerning my professional qualifications and competence, ethics, character and other information pertaining to me to ECFMG and FCVS.

I further request and authorize that the requested information, documents and records be sent directly to:

Educational Commission for Foreign Medical Graduates
3624 Market Street
Philadelphia, PA 19104

Immunity and Release

I hereby extend absolute immunity to, and release, discharge and hold harmless from any and all liability: 1) ECFMG and FCVS and their respective agents, representatives, directors and officers; 2) other licensing boards, government agencies, institutions, hospitals and clinics providing information pursuant to this Authorization, and their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by ECFMG or FCVS.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons must be sent directly by such persons to ECFMG. I understand that ECFMG will not accept such information, records or documents forwarded by me.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid from the date signed.

Signature Date of Signature

Printed Last Name, First Name, Middle Initial, Suffix e.g., Jr.

Date of Birth (month/day/year)

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself (alone) Sign across the bottom or top of the photo. Do not sign the back.



Form of Medical School Release Request

Please complete, sign and date this form and return it with your application.

\_\_\_\_\_  
Name of Medical School

\_\_\_\_\_  
Address of Medical School

\_\_\_\_\_  
City, State/Province, Postal Code

\_\_\_\_\_  
Country

**Re: Name:** \_\_\_\_\_  
(Applicant Name)

**USMLE/ECFMG ID No.** (if known): \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_  
Day/Month/Year

**Date of Graduation:** \_\_\_\_\_  
Month/Year

Dear Sir or Madam:

I am currently applying to the Federation Credentials Verification Service (“FCVS”). To facilitate this process, I hereby request:

- An official, final medical school transcript that bears your institution’s seal and the signature of an authorized representative; and
- Certification of the enclosed final medical diploma, by affixing the institution’s seal and the signature of an authorized representative on to the diploma; and
- The Dean, or an authorized representative, of your Medical School to complete the attached form titled “**Verification of Medical Education.**”

Please send the “**Verification of Medical Education**” form, certified diploma and official, signed transcript to FCVS’ service provider, Educational Commission for Foreign Medical Graduates (“ECFMG”), in the enclosed, self-addressed envelope. If you have any questions about this process, please contact ECFMG by email at [deansbox@ecfm.org](mailto:deansbox@ecfm.org). Thank you for your assistance.

Sincerely,

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature