*(Please complete, sign and date this form and return it with your application)*

# Medical School Release Request

_____
Name of Institution

_____
Address

_____
City, State, ZIP Code

**Re:** **Name:** _____
***(Physician Applicant Name)***
**Social Security Number:** _____
***(Physician Applicant Social Security Number)***
**Date of Birth:** _____
***(Month) (Date) (Year)***
**Graduation Date:** _____
***(Month) (Date) (Year)***

Dear Sir or Madame:

I am currently applying for state medical licensure. As you may know, the Federation Credentials Verification Service (FCVS), a division of the Federation of State Medical Boards, acts as an agent to collect and verify credentials of licensure applicants in this state.

To facilitate this process, I hereby request:

- An official **medical school transcript** which bears your institution's seal and the signature of an authorized representative; and
- Certification of the enclosed **Medical School diploma**, by affixing the institution's seal and the signature of an authorized representative onto the diploma; and
- The Dean of your Medical School, or an authorized representative, to complete the attached form titled "**Verification of Medical Education**"; and
- A copy of the official **Dean's Letter**, if available.

Please send this information directly to FCVS in the enclosed postage-paid self-addressed envelope. If you have any questions about this process, please contact FCVS toll-free at 1-888-ASK-FCVS (1-888-275-3287). Thank you for your time and efforts.
Sincerely,

_____
Signature *(Physician Applicant)*

_____
Date of Signature