

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

\_\_\_\_\_  
Name of Institution

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP Code

\_\_\_\_\_  
**Physician Applicant Name**

\_\_\_\_\_  
**Physician Applicant Social Security Number** (Last 4 digits only)

\_\_\_\_\_  
**Physician Applicant Date of Birth** (Month) (Date) (Year)

\_\_\_\_\_  
**Physician Applicant Graduation Date** (Month) (Date) (Year)

Dear Sir or Madam:

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
- Certification of the enclosed **Medical School diploma**, by affixing the institution's seal and the signature of an authorized representative onto the diploma
- The Dean of your Medical School, or an authorized representative, to complete the attached form titled "**Verification of Medical Education**"
- 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