



MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ Birthdate _____ Last 4 digits of SSN _____

Signature _____ Date _____

Date of Degree _____ Degree Received _____

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) _____

MATRICULATED IN:(Name of School) _____

AT:(Location of School) _____

AND RECEIVED A DIPLOMA CONFERRING:(Degree) _____

ON:(Month, Day, Year) _____

ANY DISCIPLINARY ACTION? Yes* _____ No _____
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes* _____ No _____
(N/A is not an acceptable response)

School
Seal**

President, Secretary, Dean, Registrar:

Print Name _____

Signature _____

Date _____

Phone Number _____

Fax Number _____

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.