CERTIFICATE OF MEDICAL EDUCATION

(Applicant must forward this application form to medical school granting degree for certification of his/her medical education)

It is hereby certified that _____

(1) NAME

received a _____ diploma from _____

(2) DEGREE (3) SCHOOL

_____ on _____

(4) LOCATION (5) MM/DD/YY

Signed _____

(SEAL OF COLLEGE)

_____

(TITLE)

Date this Certificate _____

INSTRUCTIONS TO MEDICAL SCHOOL

The person whose name appears on this certificate has applied for a license to practice medicine in the State of North Dakota.

Please review this certificate to determine if the statement is correct. If you find that it is entirely correct, please:

A. Complete the portion of the form calling for your name, your title, and the date.
B. Affix the official seal of your institution.
C. Return this certificate to the North Dakota Board of Medicine via email at license@ndbom.org, mail: 4204 Boulder Ridge Rd, Suite 260; Bismarck, ND 58503; or fax to 701-989-6392.

INSTRUCTIONS TO APPLICANT

1. Type your name on Line (1).
2. Indicate what medical school diploma you received on Line (2).
3. Type the name of your medical school on Line (3).
4. Type the address of your medical school on Line (4).
5. Type the date **(month/day/year)** you received your medical school diploma on Line (5).
6. Send this form to the President, Dean, or Registrar of your medical school.