Medicine Education Record Form

Instructions: Please complete this form and return it to the Office of the Professions at the address at the end of the form. Your signature must be notarized by a Notary Public.

1. Social Security Number

2. Birth Date  Month ☐ Day ☐ Year ☐

3. Print Name
   Last
   First
   Middle

4. Mailing Address (you must notify the Department promptly of any address or name changes using the Address/Name Change Form which can be found on our Web site at www.op.nysed.gov/anchange.pdf.)
   Line 1
   Line 2
   Line 3
   City
   State
   Zip Code
   Country/Province

5. Affidavit With Acknowledgment (Notarization required.)

Applicant

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. This form must be signed and dated in the presence of a Notary Public.

Signature of the applicant: ______________________________________________________________________________________

Date __________ / __________ / __________

Notary

State of ____________________________ County of ____________________________

On the __________ day of ____________________ in the year __________ before me, the above signed, personally appeared ______________________________________________________________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _________________________________________________________________________________________

Notary ID number _______________________________  Notary Stamp

Expiration date __________ / __________ / __________
Please print clearly giving an accurate record of your educational preparation below. You must complete all information for all schools/colleges/universities attended and diplomas and/or degrees received or your application will be considered incomplete. Attach additional sheets if necessary.

Name of High School/Secondary School or GED Diploma issuer:

City: ________________________________ State/Province: _________________________ Country: __________________________

Number of years attended: ____________________ Attendance from: _______ / _______ / _______ to _______ / _______ / _______
mo. day yr. mo. day yr.

Graduation date: _______ / _______ / _______ or Date GED issued: _______ / _______ / _______
mo. day yr. mo. day yr.

Postsecondary/Preprofessional Education (Exclusive of Medical School)

Name of School: _________________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________ Attendance from: _______ / _______ / _______ to _______ / _______ / _______
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): ___________________________________________________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______
mo. day yr.

Name of School: _________________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________ Attendance from: _______ / _______ / _______ to _______ / _______ / _______
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): ___________________________________________________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______
mo. day yr.

Medical Education (Professional, list all medical schools attended)

Name of School: _________________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________ Attendance from: _______ / _______ / _______ to _______ / _______ / _______
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): ___________________________________________________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______
mo. day yr.

Name of School: _________________________________________________________________________________________________

City: ________________________________ State/Province: _________________________ Country: __________________________

Major/Concentration: ___________________________________________________________________________________________

Number of years attended: ____________________ Attendance from: _______ / _______ / _______ to _______ / _______ / _______
mo. day yr. mo. day yr.

Title of Degree/Diploma/Certificate awarded (in the original language): ___________________________________________________________________________________________

Date Degree/Diploma/Certificate awarded: _______ / _______ / _______
mo. day yr.