

SECTION II : CERTIFICATION OF PROFESSIONAL EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information required in Item 5 and send directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

1 **For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:**
Applicant met LCME/AOA requirements for admission to medical/osteopathic school? YES NO
If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours

2 Did the applicant receive advanced standing based on prior academic work? YES NO
If Yes, indicate when the prior work was completed below and submit **an official transcript of studies at your institution**, and copies of documentation in your file to support the granting of transfer credit.
Name of Institution: _____ Dates of attendance: _____ to _____

3 Applicant's Entrance date: _____ / _____ / _____ Completion Date: _____ / _____ / _____

4 Degree/diploma conferred: _____ Date of conferral: _____ / _____ / _____

5 **For All Other Applicants:**
Years of education required for admission into your medical school: _____
Preprofessional credential/degree submitted by applicant for admission into your medical school: _____
Was Social Service required? YES NO If Yes, give inclusive dates and name of institution in which requirement was met.
Institution: _____ Dates: _____ to _____
Was a pre-graduation internship required? YES NO If Yes, give inclusive dates and name of institution in which requirement was met.
Institution: _____ Dates: _____ to _____

Submit with this form:

- A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit or convalidation.
The transcript must bear the original signature of the registrar, dean, principal or rector and original seal of the school.
- B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.
- C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: _____ Date: _____ / _____ / _____

Type or print name: _____

Title: _____

Medical school: _____


Address: _____

Telephone: _____ Fax _____

E-mail address: _____

(SEAL)

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this form Directly to: 

New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.