**FORM 2**

**MEDICINE**

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
www.op.nysed.gov

# CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

## APPLICANT INSTRUCTIONS

**Use this form only if you attended a New York State registered or LCME/AOA accredited medical school.**

1. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required.
2. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., SEESCYT).
3. This form must be signed by the Registrar of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope to the address at the end of this form. **This form will not be accepted if returned by the applicant or any other party.**

## SECTION I: APPLICANT INFORMATION

**1** **Social Security Number**

*(Leave this blank if you have no U.S. Social Security Number)*

**2** **Birth Date**

*Month* *Day* *Year*

**3** **Print Full Name Exactly as It Appears on Your Application for Licensure (Form 1), Or Application for Limited Permit (Form 5B)**

Last

First

Middle

**4** **Mailing Address:** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State

Zip Code

Country/ Province

**5** **Telephone/E-Mail**

**Daytime Phone**

Area Code

Phone Number

**E-Mail Address** (Please print clearly)

**6** Print name under which your degree or diploma was awarded *(if different from above)* : _____

**7** Professional School Attended: _____

Address: _____

**8** Name of Degree/Diploma: _____ Date awarded: _____

**9** I request and give my permission to the school listed in item 7 above to complete Section II of this form and mail it to the New York State Education Department at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's signature: _____ Date: _____ / _____ / _____
*mo.* *day* *yr.*



**CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL IS TO BE MADE ON NEXT PAGE**

## SECTION II: CERTIFICATION OF PROFESSIONAL EDUCATION

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

**1**

Applicant Name: _____

***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: _____ / _____ / _____ (mo. day yr.) Completion Date: _____ / _____ / _____ (mo. day yr.)

**4**

Degree/diploma conferred: _____

Date of conferral: _____ / _____ / _____ (mo. day yr.)

**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:* _____ / _____ / _____ (mo. day yr.)

*Type or print name:* _____

*Title:* _____

*Medical school:* _____

*Address:* _____

_____

**(SEAL)**

*Telephone:* _____

*Fax* _____

*E-mail address:* _____

**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 Unit, 89 Washington Avenue, Albany, NY 12234-1000. |
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