UCI School of Medicine
Office of Graduate Medical Education

MEDICAL BOARD VERIFICATION OF TRAINING REQUEST FORM

Date: _____
Requested by: _____
Maiden Name (if applicable): _____
Contact Number: _____
Email Address: _____

Training Program(s) Completed at UC Irvine:

_____ Dates: _____
_____ Dates: _____
_____ Dates: _____

Attestation

By signing this form, I confirm that I completed training at UC Irvine in the program(s) listed above during the dates provided. I am requesting that the UC Irvine Office of Graduate Medical Education complete the attached medical board verification form which is required as part of the application process. I understand that there is a $50 processing fee, per verification to a board, associated with this request.

Print Legal Name of Authorizing Physician: _____

Signature of Authorizing Physician: _____

Date: _____

State of _____

County of _____

Your signature must be acknowledged before a Notary Republic.

Notary Section

On this ____ day of _____, 20__, before me personally appeared _____ to me known to be the person described in and who executed the foregoing instrument and acknowledged the s/he executed the same as his/her free and voluntary act and deed.

Print Name: _____

Notary Public, State of _____ (Seal)

My commission expires: _____

This document is good for one year from the last date of signature.