UC IRVINE 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.