

MEDICAL EDUCATION VERIFICATION FORM

APPLICANT: **Please forward this form to your medical school to complete.**

MEDICAL SCHOOL: The Marshfield Clinic Health System Division of Education requests that you complete this form concerning the following individual to start their residency training:

Applicant's Name:

Medical School:

Medical School Address:

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| 1. Did this individual attend the medical school noted above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What were the applicant's dates of enrollment in this medical school? | | |
| Start Date: <input type="text"/> / <input type="text"/> / <input type="text"/> | | |
| End Date: <input type="text"/> / <input type="text"/> / <input type="text"/> | | |
| 3. Did this individual graduate from this medical school? If no, please attach explanation on a separate sheet. | | |
| Degree Granted: <input style="width: 200px;" type="text"/> | | |
| Date Degree Granted: <input type="text"/> / <input type="text"/> / <input type="text"/> | | |
| 4. Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did this individual have a record of unexcused absences during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was this individual recommended for post-graduate training? If no, please attach explanation on a separate sheet | <input type="checkbox"/> | <input type="checkbox"/> |

Printed Name of Dean:

Signature: _____ Date / /

Medical School, please return this completed form directly to:
guidry.amy@marshfieldclinic.org (if using email, please make sure the school seal is noticeable)

OR
Marshfield Clinic Health System
Division of Education-1R6
Amy Guidry
1000 N Oak Ave
Marshfield WI 54449

**SEAL OF
MEDICAL SCHOOL**