Medical Degree Verification Form

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FL 32399-3253
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO:
   Name of medical school
   Street address
   City - State - Zip - Country

2. Name: ______________________________________

3. Date of Birth: _______________________

4. Type of Degree: _______________________ Date Degree Received: __________

Authenticate by signature and school seal.

________________________________________________________________________

Verified by

SEAL

________________________________________________________________________

Name

Title