If you are using FCVS do not submit this form.

Complete verifications must be sent directly from the medical education institution to the board office by fax to (850) 412-1268 or by mail to:

Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3257

Board of Medicine
Medical Degree Verification

Name: ____ Date of Birth: ______________
MM/DD/YYYY

Part I: To be completed by applicant

Name of Medical School: ____

Address: ____

City: ______________________________ State: _____________________________________ ZIP: _____________

Part II: To be completed by Medical Education Institution

The above-named doctor has applied for licensure in the state of Florida. Please complete this section and submit to the above address.

Type of degree awarded: _________________________________

Date degree received: ________________
MM/DD/YYYY

Verifier Name ____ Title ____________________________

Signature ____ Date ______________
MM/DD/YYYY

Affix school seal