
CERTIFICATE OF MEDICAL EDUCATION

(Applicant must forward this application form to medical school granting degree
for certification of his/her medical education)

It is hereby certified that _____
(1)

received a _____ diploma from _____
(2) (3)

_____ on _____ and to the
(4) Location (5) MM/DD/YY

best of our knowledge is of good moral character.

Signed _____

(SEAL OF
COLLEGE)

(TITLE)

Date this Certificate _____

INSTRUCTIONS TO MEDICAL SCHOOL

The person whose name appears on this certificate has applied for a license to practice medicine in the State of North Dakota.

Please review this certificate to determine if the statement is correct.

If you find that it is entirely correct, please:

- A. Complete the portion of the form calling for your name, your title, and the date.
- B. Affix the official seal of your institution.
- C. Return this certificate to the North Dakota State Board of Medical Examiners,
418 E. Broadway Ave., Suite 12; Bismarck, ND U.S.A. 58501 or FAX to 701-328-6505 Original
must follow faxed copy via US mail or another courier.

-Thank You-

3-07

INSTRUCTIONS TO APPLICANT

1. Type your name on Line (1).
2. Indicate what medical school diploma you received on Line (2).
3. Type the name of your medical school on Line (3).
4. Type the address of your medical school on Line (4).
5. Type the date (month/day/year) you received your medical school diploma on Line (5).
6. Send this form to the President, Dean, or Registrar of your medical school.