The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Medicine Form 2
Certification of Professional and Preprofessional Education

Use this form only if you attended a New York State registered or LCME/AOA/CACMS accredited medical school.

Applicant Instructions

1. Complete Section I and sign and date item 9.

2. Send the entire Form 2 to the institution(s) you attended, including any fee required by the institution, and have the registrar complete Section II and return all pages in an official school envelope directly to the Office of the Professions at the address at the end of this form. Form 2 will not be accepted if submitted by the applicant or if it is received in a personal envelope. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., SEESCYT).

Section I: Applicant Information

1. Social Security Number
(Leave this blank if you do not have a U.S. Social Security Number)

2. Birth Date Month Day Year

3. Print Name Last

First

Middle

5. Telephone/Email Address
Daytime Phone
☐ Home or ☐ Business

Area Code Phone

Email Address (please print clearly)
☐ Home or ☐ Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
(You must notify the Department within 30 days of any address or name changes)

Line 1

Line 2

Line 3

City

State ZIP Code

Country/ Province

6. New York State DMV ID Number (Driver or Non-Driver ID)
(Leave this blank if you do not have a New York State DMV ID Number)

7. Name as it appears on your Degree/Diploma/Certificate _____

8. Name of institution attended _____

Address of institution _____

Title of Degree/Diploma/Certificate awarded (in original language) _____

Date Degree/Diploma/Certificate awarded ____ mo. ____ yr. ☐ Not yet awarded

9. I request and give my permission to the institution listed in item 8 above to complete Section II of this form and mail it to the Office of the Professions at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application.

_____ Signature

_____ Date

Section II: Certification of Professional Education

Instructions to the Registrar: Complete Section II and sign the Certification. Return the entire form along with any required documentation in an official school envelope directly to the Office of the Professions at the address at the end of this form. **Form 2 will not be accepted if submitted by the applicant.**

Name of the applicant _____

(see Section I, item 7)

1. Applicant met LCME/AOA/CACMS requirements for admission to medical/osteopathic school? ☐ Yes ☐ No

   If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to

   medical school _____ semester hours _____ quarter hours.

2. Did the applicant receive advanced standing based on prior academic work? ☐ Yes ☐ No

   If yes, indicate when the prior work was completed below and submit an official transcript of studies at your institution, and copies of documentation in your file to support the granting of transfer credit.

   Name of institution _____

   Dates of attendance _____ to _____

3. Applicant's Entrance Date ___ ___ ___ (mo. day yr.) Completion Date ___ ___ ___ (mo. day yr.)

4. Degree/diploma conferred: _____

   Date of conferral ___ ___ ___ (mo. day yr.)

Certification - To be completed by the Registrar

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

_____ _____

Signature of Registrar Date

Print Name _____

Title or official position _____

Institution _____

Address _____ Seal

_____

Telephone _____ Fax _____

Email _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Unit, 89 Washington Avenue, Albany, NY 12234-1000. OR, Submit this form to the Department by E-mail at DPLSEduc@nysed.gov.