MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.

Registrar Confirmation of Medical School Graduation Form

The Medical College of Wisconsin Affiliated Hospitals, Inc. (MCWAH) requires primary verification of your medical school graduation.

Please complete the top portion of this form, then send the entire form to your Medical School registrar as soon as possible. **The registrar will send it directly to MCWAH after you have graduated.**

You will not be able to begin your program until the Registrar Confirmation is returned to MCWAH from your medical school. **Please make sure you know the Registrar contact person's name, phone number and email address for this, in case you need to follow-up!**

If your name is different than that listed on your confirmation, please send copies of legal paperwork explaining name change (marriage certificate, divorce decree, etc.) to MCWAH in the enclosed envelope.

Foreign Medical Graduates are exempt from this requirement, see ECFMG Certificate information.

Incoming housestaff from MCW or UW Medical Schools do not need to complete this form.

MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.

AUTHORIZATION FOR REGISTRAR CONFIRMATION OF GRADUATION

*Foreign Medical Graduates and Incoming housestaff from MCW or UW Medical Schools do not need to complete this form.

PLEASE COMPLETE THE TOP PORTION OF THIS FORM, THEN SEND FORM TO THE REGISTRAR OF YOUR GRADUATING MEDICAL SCHOOL. (Send entire form - they will complete the bottom half).

I have applied for employment in a graduate medical education training program at the Medical College of Wisconsin Affiliated Hospitals Inc. (MCWAH). Verification of medical education is required by MCWAH for my employment.

I hereby authorize and request _____ to send verification of my graduation from this medical school to MCWAH.
(Medical School)

Print Name _____

Signature _____

Date of Birth _____

Social Security # or School ID # (for identification purposes only)_ _____

If name changed (through marriage or otherwise), print former name(s) here _____

MEDICAL SCHOOL

Registrar,

The Medical College of Wisconsin Affiliated Hospitals, Inc. (MCWAH) requires primary verification of medical school graduation from the Registrar or Associate Dean. This verification must be sent ***after the date of completion or graduation from medical school***. Please complete and send directly to:

MCWAH
8701 Watertown Plank Rd
PO Box 26509
Milwaukee, WI 53226-0509

I certify that _____ successfully completed medical school at
(Name of Physician)

_____ on _____
(Medical School) (Insert Date of Completion or Graduation)

SCHOOL

_____
Registrar or Associate Dean for Medical Education

_____
E-mail Address & Phone Number

S E A L*

_____
Date

* If your institution does not have a seal, please indicate this on letterhead.