

# 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

*\*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 \_\_\_\_\_

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### 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

SEAL\*

\_\_\_\_\_  
Date

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