Bureau of Professional Licensing
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CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: 1978 PA 368

This form must be submitted directly to this office by the dean or registrar of medical school. If this form is submitted by the applicant, it will not be accepted.

Applicant Information:

Applicant's First Name	Middle Name	Last Name	Date of Birth (MM/DD/YYYY)
Address			
City	State	Zip Code	
Telephone Number	Email Address		
Name of Medical School			

Remainder of Form to be Completed by the Dean or Registrar of the Medical School

Name of Medical School		
Address of Medical School		
City	State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above was / will be granted the degree of ____

on ______________________________.
(Month/Day/Year)

____ ____
Signature of Dean or Registrar Date

____ (Seal)
Print or Type Name of Dean or Registrar

NOTE: Form will not be accepted if submitted more than 3 months prior to graduation and/or the date of application for licensure.

LARA/BPL-MEDCERTEDUS (Rev. 8/18)

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