

State of Nebraska, Department of Health and Human Services  
Division of Public Health, Licensure Unit  
301 Centennial Mall South,  
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

**VERIFICATION OF FOREIGN MEDICAL COLLEGE**

\_\_\_\_\_  
Name of University

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

I, \_\_\_\_\_, MD/DO have applied for a license to practice in the State of Nebraska.  
(Print full name)

**As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.**

**I hereby authorize \_\_\_\_\_, its staff or representative to provide the State of Nebraska**  
(Name of College)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of Applicant) MO DAY YEAR

Social Security Number \_\_\_\_\_ Date of Graduation \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that \_\_\_\_\_  
(Full name of applicant)

Enrolled in \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_ graduated \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Name of Foreign Medical College) MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of \_\_\_\_\_

**Any disciplinary action on file? Yes (please explain) \_\_\_\_\_ No \_\_\_\_\_**

**Further, the records of this institution indicate that the attached photograph (check one) \_\_\_\_\_ Represents a true likeness of the above named applicant \_\_\_\_\_ Does not represent a true likeness of the above-named applicant.**

By \_\_\_\_\_  
**Original Signature** of the dean or registrar  
(stamped or electronic signatures will NOT be accepted)

SEAL Attach  
Passport size  
Photograph Here

\_\_\_\_\_  
Print or Type Official's Name and Title

\_\_\_\_\_  
e-mail address if possible

Signed and the college Seal affixed on \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical College seal MUST be imprinted partially on photograph  
MO Day Year