



Commonwealth of Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880

ELECTIVE MEDICAL SCHOOL CLINICAL STUDY VERIFICATION

FORM E-2 is only for applicants who have completed any required or more than three (3) months of elective medical school clinical study as a part of the two (2) year medical school clinical study requirement without onsite supervision and evaluation of the faculty of the medical school in which the applicant was enrolled at the time of study at a training facility under the direct supervision of the medical school faculty.

INSTRUCTIONS: A COPY OF THIS FORM MUST BE SUBMITTED BY THE APPLICANT DIRECTLY TO EACH TRAINING INSTITUTION WHERE YOUR OFFSITE CLINICAL TRAILING WAS COMPLETED. FORMS MUST BE RETURNED DIRECTLY TO THE BOARD OF REGISTRATION IN MEDICINE. THIS FORM MAY BE DUPLICATED AS NECESSARY.

Name of Applicant: _____

Clinical Area: _____ Type (Elective or Required): _____

Dates of Attendance: From ___/___/___ To ___/___/___ Weeks of Credit: _____

Name of Instructor or Supervisor: _____

Name of Program Director: _____

Is/was instructor/supervisor fully-licensed to practice medicine in your state/country? [] YES [] NO

If hospital is in the United States, is program approved by ACGME? [] YES [] NO

If hospital is outside the U.S. or is non-ACGME approved, how many beds does the hospital have? _____

Did the Dean of the student's medical school approve the student's participation in this program in advance? [] YES [] NO

Did the supervisor of this clinical training hold a faculty appointment at the student's medical school? [] YES [] NO

If yes, indicate term of appointment (Dates): From: ___/___/___ To: ___/___/___

Number of students from applicant's school who simultaneously participated in this clerkship: _____

Number of students from U.S. medical school(s) affiliated with this hospital who simultaneously participated in this clerkship: _____

Name(s) of U.S. medical school(s) affiliated with this hospital: _____

PLEASE PROVIDE A COPY OF THE STUDENT'S EVALUATIONS FOR THIS CLERKSHIP AND ANY ADDITIONAL INFORMATION REGARDING THE APPLICANT'S CLINICAL TRAINING EXPERIENCE AT YOUR INSTITUTION.

SIGNED: _____

DATE: _____

Name and Title (please print or type): _____

Name and Address of Institution: _____

HOSPITAL SEAL (If no seal, indicate so) _____