

MEDICAL SCHOOL STUDENT/GRADUATE CONSENT FOR RELEASE OF USMLE TRANSCRIPT

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Recipient Information
(To be completed by School Official)

Contact Name	
Title	
Institution Name	
Mailing Address: Line 1	
Mailing Address: Line 2	
City	State/Province
ZIP/Postal Code	Country
Country/Area Code and Telephone Number	Country/Area Code and Fax Number
E-mail Address	

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Authorization
(To be completed by the Student or Graduate for whom the USMLE Transcript is being requested)

I hereby authorize and request the Educational Commission for Foreign Medical Graduates to release my official United States Medical Licensing Examination (USMLE) transcript to the individual at the institution listed above.

Signature of Student
(Using the Latin Alphabet)

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Date (Month/Day/Year)

Name of Student
(Please Print)

USMLE/ECFMG ID # - - -

Date of Birth
(Month/Day/Year)

/ /

This form is available on the ECFMG website at www.ecfm.org.