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Kansas

THIS FORM IS TO BE USED FOR ALL REQUESTS FOR VERIFICATION OF FOREIGN SCHOOLS

Please enter required information. E-mail, fax.or mail form.

Applicant's Name: _____

ECFMG# _____

Name of Medical School: _____

City and Country of Medical School: _____

Send Information to: _____

Address: _____

E-mail: _____ Fax: _____

Bottom Section to be completed the Kansas Board of Healing Arts.

K.S.A. 65-2873 requires an applicant for a license to practice medicine and surgery to have graduated from a school approved by the Board. If the school has not been approved by the Board, an applicant may still be eligible for a license if the school has not been disapproved and has been in operation (date instruction started) for not less than 15 years

The following has been verified and
- ☐ APPROVED or BEEN IN OPERATION FOR 15 YEARS
- ☐ DISAPPROVED
- ☐ HAS NOT BEEN IN OPERATION FOR 15 YEARS

Name of Medical School: _____

Date Instruction Started: _____

Verified By: _____ Title: _____

Signature: _____ Date: _____

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