Request for Duplicate Permanent Validation Sticker
Form 296

THIS FORM IS TO BE USED BY ECFMG® CERTIFIED PHYSICIANS WHO WISH TO REQUEST A DUPLICATE PERMANENT VALIDATION STICKER FOR EXAMINATION DATE(S) LISTED ON THEIR STANDARD ECFMG CERTIFICATE.

All requested information must be provided. Please type or print carefully. Return completed form to ECFMG at 3624 Market Street, Philadelphia, PA 19104-2685 or by fax to 215-386-9767.

COMPLETE ALL FIELDS

USMLE™/ECFMG Identification Number ☐-☐ ☐ ☐-☐ ☐ ☐-☐

Name _____
First Middle Initial Last

Mailing Address (Where the sticker should be sent)

_____

_____

_____
City State Zip or Postal Code

_____
Country

_____ _____
Phone Number E-mail Address

Is this a change in address for ECFMG records? **Yes** ☐ **No** ☐

Reason for requesting a duplicate permanent validation sticker:
(√ Check which reason applies)

☐ Sticker Never Received or Lost

☐ Sticker Destroyed or Unusable

☐ Other (Please specify) _____

I hereby request a duplicate permanent validation sticker.

_____ _____
Signature Date