Medical School Release Request
Form 345-I

You must submit the *Medical School Release Request* (Form 345) when you send your final medical diploma to ECFMG®.

The *Medical School Release Request* (Form 345) is addressed to your medical school. By completing this form, you are authorizing your medical school, if requested by ECFMG, to provide and/or verify your medical credentials and provide information on your medical education. ECFMG will send a copy of your completed *Medical School Release Request* (Form 345) to your medical school with its request.

INSTRUCTIONS

Complete the *Medical School Release Request* (Form 345) by printing the name and address of your medical school (the medical school from which you graduated), your name, USMLE®/ ECFMG Identification Number, your date of birth, and month and year of graduation from medical school in the spaces provided. You must also attach a current, full-face, passport-sized color photograph of yourself, and sign and date the form where indicated.

Submit two copies of the completed *Medical School Release Request* (Form 345) to ECFMG with your medical education credentials.

If you are applying to ECFMG for an examination and you do not have a valid *Certification of Identification* (Form 186) on file with ECFMG, the completed copies of the ECFMG *Medical School Release Request* (Form 345), medical education credentials, photograph, and any other required documents must be sent with your *Certification of Identification Form* (Form 186). These forms and documents must be sent to ECFMG in one envelope. If your Form 186 is signed by an authorized official of your medical school, this envelope must be sent to ECFMG directly from the office of that official. If your Form 186 is certified **only** by a Consular Official, Notary Public, First Class Magistrate, or Commissioner of Oaths, this envelope can be sent to ECFMG by you.

If you have a valid *Certification of Identification Form* on file with ECFMG, send the documents outlined above to ECFMG in one envelope.

If you are not currently applying for an examination, you still may submit your medical education credentials and associated forms and documents.

These forms and documents must be sent to:
ECFMG
3624 Market Street, 4th Floor
Philadelphia, PA 19104-2685
USA

The *Medical School Release Request* (Form 345) is available on the ECFMG website at www.ecfmg.org.

Medical School Release Request
Form 345

Please complete, sign, and date this form. This form must be sent to ECFMG with your medical education credentials.

Name of Medical School

Address of Medical School

City, State/Province, Postal Code

Country

Re: Name: _____
Applicant Name – Last First Middle

USMLE/ECFMG ID No. ☐-☐☐☐-☐☐☐-☐

Date of Birth: _____
Day / Month / Year

Date of Graduation: _____
Month / Year

PHOTOGRAPH:

Attach a current, full-face, passport-sized color photograph of yourself here. Use tape or glue; no staples or paper clips please.

A photocopy of your photograph is not acceptable.

Dear Sir or Madam:

I am currently applying to the Educational Commission for Foreign Medical Graduates (ECFMG®). To facilitate this process, I hereby request:

- An official, final medical school transcript which bears your institution's seal and the signature of an authorized official; and
- Certification of my Final Medical Diploma, by affixing the institution's seal and the signature of an authorized official onto the diploma; and
- An authorized official of your Medical School to provide the requested information on my medical education.

If you have any questions about this process, please contact ECFMG by e-mail at deansbox@ecfmg.org. Thank you for your assistance.

Sincerely,

Signature of Applicant

Date of Signature

Medical School Release Request
Form 345

Please complete, sign, and date this form. This form must be sent to ECFMG with your medical education credentials.

Name of Medical School

Address of Medical School

City, State/Province, Postal Code

Country

Re: Name: _____
Applicant Name – Last First Middle

USMLE/ECFMG ID No. ☐-☐☐☐-☐☐☐-☐

Date of Birth: _____
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