



# MEDICAL SCHOOL STUDENT/GRADUATE CONSENT FOR RELEASE OF USMLE TRANSCRIPT

**3**  
**Recipient Information**  
(To be completed by School Official)

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

**4**  
**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)

□□/□□/□□□□

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](http://www.ecfm.org).

