

**Geisinger Health System**

**REQUEST FOR VERIFICATION OF MEDICAL SCHOOL GRADUATION**

**AUTHORIZATION TO RELEASE INFORMATION (Please Print or Type):**

I, \_\_\_\_\_, authorize the institution named below to release the requested information to the Office of Medical Education, Geisinger Medical Center, 100 North Academy Avenue, Danville, PA 17822-1334, for the stated purpose.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

**MEDICAL SCHOOL NAME AND ADDRESS (Please Print or Type):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VERIFICATION BY MEDICAL SCHOOL NAMED ABOVE: (To be completed by Medical School)**

\_\_\_\_\_  
Degree

\_\_\_\_\_  
Date Awarded/To Be Awarded

\_\_\_\_\_  
Person Verifying (print name and title)

\_\_\_\_\_  
Date of Verification

\_\_\_\_\_  
Signature of Person Verifying

**Affix School Seal Here**