



Surname and name(s)*			
Date of Birth (dd/mm/yyyy)		USMLE/ECFMG ID #	
Email address			
Telephone #			

I hereby authorize and request the Educational Commission for Foreign Medical Graduates to release my official USMLE transcript to the Jagiellonian University Medical College (JU MC).

The data obtained thereby will only be used by the JU MC for statistical purposes and NOT shared with any third party.

Signature		Date (dd/mm/yyyy)	
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*please type

Instructions: Please TYPE in all required information and sign the form. Incomplete forms will NOT be recognized by the JU MC SME. Failure to deliver the form to the JU MC SME will prevent your USMLE application from being processed by the School Office. Please return the form to the JU MC by post, e-mail (only pdf files), or fax, or in person.

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