



**EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG®)
INTERNATIONAL CREDENTIALS SERVICES**

**LICENSING AUTHORITY: MEDICAL AND DENTAL PROFESSIONS BOARD
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**

Application for Verification of Credentials

Check if you have previously applied to EICS. Complete application. Include EICS identification number in Item 3. See Instructions for Documentation (Item 8) and Fee (Item 9) information.

<p>1. Name</p> <p>Enter your complete name and any maiden/alternate name.</p>	<p>_____</p> <p>Last Name (Surname) and Generational Suffix</p> <p>_____</p> <p>First and Middle Name(s)</p> <p>_____</p> <p>Maiden/Alternate Name(s)</p>
<p>2. Contact Information</p> <p>Enter your mailing address, telephone and fax numbers and email address.</p>	<p>_____</p> <p>Street Address/Post Office Box</p> <p>_____</p> <p>Address Continued</p> <p>_____</p> <p>City</p> <p>_____</p> <p>State/Province</p> <p>_____</p> <p>Country</p> <p>_____</p> <p>Postal/Zip Code</p> <p>_____</p> <p>Telephone Number</p> <p>_____</p> <p>Fax Number</p> <p>_____</p> <p>Email Address (Please type or print clearly)</p>
<p>3. Identification Number(s)</p> <p>Enter the Medical and Dental Professions Board, USMLE/ECFMG, and EICS identification numbers, if assigned.</p>	<p>_____</p> <p>Medical and Dental Professions Board Identification Number</p> <p>_____</p> <p>USMLE/ECFMG Identification Number</p> <p>_____</p> <p>EICS Identification Number (if previously assigned)</p>
<p>4. Date and Place of Birth</p> <p>(Enter your date and place of birth.)</p>	<p>_____</p> <p>Day</p> <p>_____</p> <p>Month</p> <p>_____</p> <p>Year</p> <p>_____</p> <p>City</p> <p>_____</p> <p>State/Province</p> <p>_____</p> <p>Country</p>

Visit the EICS website at www.ecfmg.org/eics for information on EICS and the EICS application

Office Use Only
EICS Identification No.

5. Medical School(s)

List **all** medical schools attended **outside of South Africa**, not just the one from which you graduated.

If you attended more than two medical schools, photocopy this page to list the additional medical schools.

You must also include legible copies of your medical diploma and medical school transcript. If the documents are not in English, you must include official English translations.

See Items 5 and 8 of attached instructions.

Medical School of Graduation:

Full Name of Medical School

Street Address/Post Office Box

Address Continued

City

State/Province

Country

Postal/Zip Code

Telephone Number

Fax Number

Attended From _____ to _____
Month/Year Month/Year

Graduation Date (Month/Year)

Medical Degree Date (Month/Year)

Other medical school(s) attended:

Full Name of Medical School

Street Address/Post Office Box

Address Continued

City

State/Province

Country

Postal/Zip Code

Telephone Number

Fax Number

Attended From _____ to _____
Month/Year Month/Year

If additional sheet(s) listing other medical schools attended are enclosed, please check:

Additional sheet(s) enclosed.

6. Postgraduate Medical Education

List **all** postgraduate medical education obtained after graduation from medical school, **outside of South Africa**. Include internships, residencies and fellowships.

If your postgraduate medical education was at more than two institutions, photocopy this page to list the additional institutions.

You must also include legible copies of the certificates confirming your postgraduate medical education. If the documents are not in English, you must include official English translations.

See Items 6 and 8 of attached instructions.

Most Recent Postgraduate Medical Education:

Full Name of Institution _____

Street Address/Post Office Box _____

Address Continued _____

City _____

State/Province _____

Country _____

Postal/Zip Code _____

Telephone Number _____

Fax Number _____

Attended From _____
Month/Year

to _____
Month/Year

Specialty _____

Position Held (check one):

Intern Resident Registrar Fellow

Other Postgraduate Medical Education:

Full Name of Institution _____

Street Address/Post Office Box _____

Address Continued _____

City _____

State/Province _____

Country _____

Postal/Zip Code _____

Telephone Number _____

Fax Number _____

Attended From _____
Month/Year

to _____
Month/Year

Specialty _____

Position Held (check one):

Intern Resident Registrar Fellow

If additional sheet(s) listing other institutions are enclosed, please check:

Additional sheet(s) enclosed.

7. Medical License/Registration

List **all** jurisdictions where a license to practice medicine was obtained **outside of South Africa**. Include permanent, limited and other special purpose license or registration.

You must also include legible copies of your medical license/registration certificate(s). If the documents are not in English, you must include official English translations.

See Items 7 and 8 of attached instructions.

Note: Item 7 is continued on page 5

Licensing/Registration Jurisdiction:

Full Name of Licensing/Registration Jurisdiction

License/Registration Number

Street Address/Post Office Box

Address Continued

City

State/Province

Country

Postal/Zip Code

Telephone Number

Fax Number

License Issue Date (Month/Year)

License Expiration Date (Month/Year)

License/Registration Status (check one)

Active Inactive Suspended Revoked

If suspended or revoked, attach a separate sheet of paper and explain the reason.

Other jurisdictions where a license/registration was obtained:

Full Name of Licensing/Registration Jurisdiction

License/Registration Number

Street Address/Post Office Box

Address Continued

City

State/Province

Country

Postal/Zip Code

Telephone Number

Fax Number

License Issue Date (Month/Year)

License Expiration Date (Month/Year)

If additional sheet(s) listing other jurisdictions are enclosed, please check:

Additional sheet(s) enclosed.

<p>7. Medical License/Registration</p> <p>Continued from page 4</p>	<p>License/Registration Status (check one)</p> <p>Active <input type="checkbox"/> Inactive <input type="checkbox"/> Suspended <input type="checkbox"/> Revoked <input type="checkbox"/></p> <p>If suspended or revoked, attach a separate sheet of paper and explain the reason.</p>
<p>8. Documentation</p> <p>Include two (2) complete and legible copies of all the documents listed here.</p> <p>Documents not in English must include English translations. See instructions for English translation requirements.</p>	<p>Medical diploma Check if included <input type="checkbox"/></p> <p>Medical school transcript Check if included <input type="checkbox"/></p> <p>Medical license(s)/registration(s) obtained from jurisdictions outside South Africa Check if included <input type="checkbox"/></p> <p>Postgraduate training certificates Check if included <input type="checkbox"/></p> <p>Additional photographs that you have signed on the back Check if included <input type="checkbox"/></p> <p>NOTE: Refer to instructions to arrange for verification shipment via courier service</p>
<p>9. Fees and Payment</p> <p>Include money order <i>or</i> credit card information.</p> <p>Applications lacking payment or payment information will not be processed</p>	<p>Fees for verification to: Medical and Dental Professions Board</p> <p>EICS verification of medical diploma, medical school transcript, medical license(s) and postgraduate training US\$150.00</p> <p><input type="checkbox"/> I have previously applied to EICS. My application fee is US\$50.00</p> <p>Money Order made payable to "EICS" enclosed: <input type="checkbox"/> US\$150.00 <input type="checkbox"/> US\$50.00</p> <p style="text-align: center;">Or</p> <p>Credit Card to be charged: <input type="checkbox"/> US\$150.00 <input type="checkbox"/> US\$50.00</p> <p>Check Card: Visa <input type="checkbox"/> Master Card <input type="checkbox"/> Discover <input type="checkbox"/></p> <p>Credit Card Number: _____</p> <p>Expiration Date: Month _____ Year _____</p> <p>Address of Card Holder: _____</p> <p style="text-align: center;">_____</p> <p>City / State / Country: _____</p> <p>Name of Card Holder: _____</p> <p>Signature of Card Holder: _____</p>

<p>Office Use Only</p> <p>EICS Identification No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make on or in connection with the application are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are true and correct.

I acknowledge that I have read and understand the "Instructions for Completing the EICS Application" and have answered all questions contained in the application truthfully and completely.

I authorize every person, medical school, university, hospital, clinic, government agency or institution having custody or control of any documents, records and other information pertaining to me to furnish to the Educational Commission for Foreign Medical Graduates (ECFMG®) International Credentials Services (EICS) any such information, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless ECFMG, the ECFMG International Credentials services, its employees, agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the ECFMG International Credentials Services to release information, material, documents, orders or the like relating to me or this application to the Medical and Dental Professions Board, Health Professions Council of South Africa at my request.

Applicant's Signature (must be signed in the presence of
a notary public, consular official or first class magistrate)

Applicant's printed last name, first name, middle initial,
suffix (e.g., Jr.)

Date of signature (must correspond to date of notarization)

*Attach one current, full-
face photo here.*

*Use tape or glue: no
staples, please.*

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this individual by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the individual and with the photograph affixed hereto, and (b) comparing the individual's signature made in my presence on this form with the signature on his/her identifying document. The statements in this document are subscribed and sworn before me by the individual on this _____ day, in the month of _____, in the year _____.

X _____
Signature of Consular Official, First Class Magistrate, Notary Public (in Latin characters with English translations, where applicable.)

Official Title

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, the undersigned, hereby authorize the Educational Commission for Foreign Medical Graduates (ECFMG®) International Credentials Services (EICS) to collect, verify and maintain information and copies of documents and records for medical registration boards to which I am applying for licensure.

I request and authorize every person, medical school, university, institution, professional licensing board, hospital, clinic, government agency or other third parties and organizations and their representatives, to release information, records, diplomas, transcripts and other documents, concerning my professional education, qualifications, experience and competence, ethics, character and other information pertaining to me to the Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services (EICS).

I further request and authorize that the requested information, records, diplomas, transcripts and other documents be sent directly to:

ECFMG International Credentials services (EICS)
4th Floor
3624 Market Street
Philadelphia, PA 19104
USA

Immunity and Release

I hereby extend absolute immunity to, and release, discharge and hold harmless from any and all liability: 1) the Educational Commission for Foreign Medical Graduates (ECFMG), 2) the ECFMG International Credentials Services (EICS), its employees, agents, representatives, directors and officers; 3) other agencies, medical schools, universities, institutions, hospitals and clinics providing information, their employees, representatives, directors and officers; and 4) any third parties and organizations for any acts, communications, reports, records, diplomas, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested and received by the Educational Commission for Foreign Medical Graduates (ECFMG) International Credentials Services. I understand that EICS will not accept such information, records or documents forwarded by me.

**A photocopy or facsimile of this authorization shall be as valid as the original
and shall be valid from the date signed.**

Signature Date of signature

Printed last name, first name, middle initial, suffix (e.g., Jr.)

Date of birth (day, month, year)

Attach one current, full-face photo here. Use tape or glue; no staples or paper clips, please.

Sign across the bottom or top of the photo. Do not sign back.