UNIVERSITY OF SASKATCHEWAN
College of Medicine
UNDERGRADUATE MEDICAL EDUCATION
MEDICINE.USASK.CA

MD Verification - Release of Information Authorization Form

From: _____

_____

_____

_____

To: Undergraduate Medical Education
3A20 Health Sciences Building
107 Wiggins Road
Saskatoon, SK S7N 5E5

To whom it may concern,

I, _____, hereby authorize the Undergraduate Medical Education Office, College of Medicine, University of Saskatchewan, to release information from my permanent student file to _____.

I also hereby confirm the following information:

Full legal name: _____

Previous legal name (if applicable): _____

Year of graduation: _____

Date of birth: _____

USASK Student #: _____

_____ _____
Signature Date