TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
School *of* Medicine

ECFMG Confirmation Authorization

Date: _____

For the purpose of confirming my ECFMG certification, I hereby authorize TTUHSC to obtain my ECFMG certification information from ECFMG.

_____
Printed Name

_____
USMLE/ECFMG Identification Number

_____
Date of Birth

_____
Signature