Secretary of State
Office of Professional Regulation
89 Main St 3rd Floor, Montpelier VT 05620-3402
sos.oprlicensing2@Vermont.gov

VETERINARIAN

Certificate of Veterinary Medical Education

APPLICANT: Complete the top of this page and forward it to your Veterinary college/school.

Applicant's Name: _____
(Last) (First) (MI) (Former)

Address: _____

Date of Birth: _____ Last Four of Social Security # _____

Name of Institution: _____

Date of Graduation: _____ Degree(s): _____

Applicant's Signature: _____ Date: _____

TO BE COMPLETED BY THE INSTITUTION GRANTING DEGREE(S): Please complete and return this form directly to the address or email listed above:

Applicant's Name: _____

Name of Veterinary College: _____

Address of College: _____

Date of Admission: _____ Date completed all requirements for graduation: _____

Date Doctorate of Veterinary Medicine was granted: _____

Was this College of Veterinary Medicine accredited by the American Veterinary Medical Association at the time of this student's graduation? **Yes** **No**

Signed _____ **Title** _____ **Date** _____
(Authorized agent of the institution)

(SEAL)