FORM J

Clinical Clerkship Affidavit & Checklist
Texas Medical Board

Required of all international medical graduates.

Applicant Name _____

Medical School _____ City_____ Country _____

1. Did you take courses for your medical education or perform clerkships in the United States **during** medical school?

   ☐ Yes - Continue to Question 2.

   ☐ No - Skip the remainder of the questions, complete the signature/date block below.

2. Have you ever been ABMS or AOA specialty board certified?

   ☐ Yes - Name of Specialty Board _____
   Skip the remainder of the questions, complete the signature/date block below.

   ☐ No – Continue to Question 3.

3. Were you enrolled in an LCME or AOA-accredited school as a **regular** student or a **visiting** student?

   ☐ Yes – Name of US medical school _____

   - Have an official with the US medical school in which you were enrolled submit a letter directly to the TMB confirming your status as a student in the school and listing your US courses/clerkships.
   - List every course you took or clerkship you performed in the US during medical school on the following chart.

   ☐ No – Continue to Question 4.

4. Did you perform the clerkship(s) in a hospital or teaching institution with an ACGME or AOA accredited graduate medical education program in the **exact same specialty or subspecialty** as the clerkship?

   ☐ Yes – Do the following:

   - List every course you took or clerkship you performed in the United States.
   - Include the ACGME/AOA ID number for each clerkship:
     ACGME –www.acgme.org/adspublic AOA - http://opportunities.osteopathic.org/index.htm
   - Have your medical school submit copies of each clerkship evaluation directly to the TMB.
   - Have your medical school submit a letter directly to the TMB confirming the number of weeks you completed in the basic science portion of your medical education. Note: Texas law requires total medical education to be at least 130 weeks.

   ☐ No – You are not eligible for licensure in Texas.

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Clerkship Performed in the United States	**Begin Date**	**End Date**	**Institution/Facility**	**City, State**	**ACGME/AOA Number (Each specialty or sub-specialty must have an individual ID number)**	**(For Office Use) Evaluation Submitted?**
Internal Medicine						
OB/GYN						
Pediatrics						
Psychiatry						
Family Medicine						
Surgery						
All Other(s). Use additional pages as needed.						

Applicant Signature _____ Date _____

Printed Name _____