APPLICATION FOR AN ELECTIVE
AT THE ALBANY MEDICAL COLLEGE
Office of Academic Affairs/Mail Code-1,
47 New Scotland Avenue, Albany, NY 12208

NAME: _____ Social Security # _____

ADDRESS: _____

_____

_____

HOME PHONE: _____

MEDICAL SCHOOL: _____: EXPECTED YEAR OF GRADUATION: _____

****

Please list in order of preference the electives for which you are applying.

ELECTIVE	ELECTIVE NUMBER	DATES

****

To be completed by the Dean of the applicant's medical school.

The above named student is a _____year medical student in a _____year program who is in good standing at this institution. The student is/is not covered by personal health insurance, is/is not covered by malpractice insurance by our institution while this student is doing this elective experience. The student is qualified and authorized to take this elective and I recommend him/her to you without reservation. An evaluation will/will not be required and the form is enclosed/will be sent.

Signature: _____ Date: _____

Name: (please print): _____

Title: _____

Please be advised a student is not considered approved for an elective until he/she receives written confirmation from the Office of Academic Affairs. If there are any problems or questions, please do not hesitate to contact this office at (518) 262-6055.