

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

NAME: _____

Social Security #: _____

ADDRESS: _____

E-Mail Address: _____
(REQUIRED)

CONTACT PHONE: _____ (REQUIRED)

MEDICAL SCHOOL: _____ **EXPECTED GRADUATION YEAR:** _____

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

ELECTIVE	INSTRUCTOR	DATES
_____	_____	_____
_____	_____	_____
_____	_____	_____

To be completed by the DEAN OR DESIGNEE of 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 THAT A STUDENT IS NOT CONSIDERED APPROVED FOR AN ELECTIVE UNTIL HE/SHE RECEIVES WRITTEN CONFIRMATION FROM THE OFFICE OF ACADEMIC AFFAIRS. IF THERE IS A PROBLEM OR QUESTIONS, PLEASE DO NOT HESITATE TO CONTACT THIS OFFICE AT (518) 262-6055.