

The University at Albany

Name: _____

E-mail Address: _____

THE PRE-HEALTH ACTIVE RECORD SHEET

Home Address _____

Local Address _____

Zip _____ Phone _____

Zip _____ Phone _____

ATTENTION STUDENTS – YOU MUST SIGN THE RELEASE BELOW.

In accordance with provisions of the Family Educational Rights and Privacy Act of 1974 (Buckley Amendment), I authorize the Advisory Committee to release letters of recommendation to each professional school as designated below.

SIGNATURE _____

DATE _____

READ INSTRUCTIONS: This sheet replaces the Initial Interest Sheet once your Committee Evaluation or individual recommendations are prepared to mail. **PLEASE** keep all information **UP-TO-DATE** throughout the application process.

YEAR OF APPLICATION _____ **REAPPLICATION?** yes no **YEAR GRADUATED** _____

APPLICATION CATEGORY AM=Allopathic Medicine OM=Osteopathic Medicine D =Dental OP=Optometry P =Podiatry V =Veterinary C =Chiropractic	I N I T I A L S	FULL NAME OF SCHOOL:	I N D I V I D U A L R E C	C O M M I T T E E V A L	D A T E M A I L E D	D A T E R E M A I L E D
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