



Evaluator's name, title, institution or place of work, email:

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Applicant  
Summer Address:

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City, State, Zip:

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Post Graduation  
Email:(e.g. gmail)

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Cell Phone:

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Applicant is applying to:

Medical School (MD, DO, DPM)  
Dental School  
Veterinary School  
Other (specify) \_\_\_\_\_

\_\_\_\_\_ I hereby waive all rights of access, which I may have now or at any time in the future to any letter of reference provided in response to this request.

\_\_\_\_\_ I do not waive any of these rights and therefore this letter should not be viewed as confidential.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

*Your electronic signature (typed name and electronic submission from your email account) indicates consent for release of this information to appropriate campus personnel, such as Pre-Health Advising. If you have any concerns with how your recommendation will be used, please contact the chair of Pre-Health Advising.*