



REQUEST FOR RECOMMENDATION

Office of Pre-Health Advisement

TO BE COMPLETED BY STUDENT

Please submit this form with each recommendation letter you request.

First Name: _____ Last Name: _____

Email: _____ Cell Phone: _____

Applying To (Please Circle):

Medicine Veterinary Dentistry Osteopathy Grad School MD/PhD Optometry Podiatry

FERPA (The Buckley Amendment):

Many professional schools prefer to review your scholastic and non-academic record with the understanding that it was obtained confidentially. Under the Family Education Rights and Privacy Act of 1974, you have the option to waive or not to waive your rights to see your records. Please check and sign below. A copy of the Family Education Rights and Privacy Act of 1974 is on file in the Yeshiva College Registrar's Office. Should you have any questions, please contact us at 646.685.0510.

_____ I DO NOT wish to waive my rights to inspect and review my scholastic and non-academic record under the Family Education Rights and Privacy Act of 1974.

_____ I HEREBY waive my rights to inspect and review my scholastic and non-academic record under the Family Education Rights and Privacy Act of 1974.

Signature: _____

Applicant's Name: _____

Date: _____

TO BE COMPLETED BY RECOMMENDER: Please be sure the recommendation letter is signed and dated, and printed on letterhead.

Signature: _____

Title: _____

Affiliation: _____

Date: _____

By signing this, I agree that this letter can be used as a reference for other programs (internship, research) to which this student applies. I also understand that the Pre-Health Office will notify me when this happens.

Please Return The Reference Letter With This Waiver Letter IN A SEALED ENVELOPE to:

Office of Pre-health Advisement
Yeshiva University
500 West 185th Street
Furst Hall, Room 111
New York, NY 10033
212.960.5395 (p)