ACCESS WAIVER

It is your right as a student to review your file in the Pre-Health professions Office. However, persons completing faculty evaluations and letters of recommendation on your behalf often prefer their statements to remain confidential. **It is our opinion that comments provided on a confidential basis are likely to be more meaningful.** Therefore, the Pre-Health Professions Office is affording you the opportunity to waive your right of subsequent access to your file.

In any event, your waiver of access is not a requirement for consideration of your application or any other services or benefits from the Pre-Health Professions Office, Charles E. Schmidt College of Science, Florida Atlantic University.

Your decision to retain or waive the right of subsequent access to your file shall be noted on all evaluation requests from the Pre-Health Professions Office, and a copy of this access waiver will be forwarded with your packet to all the professional schools of your choice.

☐ **I DO WAIVE MY RIGHT OF SUBSEQUENT ACCESS TO MY CONFIDENTIAL FILE IN THE PRE-HEALTH PROFESSIONS OFFICE, CHARLES E. SCHMIDT COLLEGE OF SCIENCE, FLORIDA ATLANTIC UNIVERSITY.**

☐ **I DO NOT Waive MY RIGHT OF SUBSEQUENT ACCESS TO MY CONFIDENTIAL FILE IN THE PRE-HEALTH PROFESSIONS OFFICE, CHARLES E. SCHMIDT COLLEGE OF SCIENCE, FLORIDA ATLANTIC UNIVERSITY.**

________________________  ____________________
Signature                              Date

(Please print name)           Student ID Number

Boca Raton • Dania Beach • Davie • Fort Lauderdale • Jupiter • Treasure Coast
An Equal Opportunity/Equal Access Institution
PRE-HEALTH PROFESSIONS OFFICE FILE INFORMATION FORM

Date: ___________________  Student ID#: ____________________________

First Name: _______________  Last Name: ____________________________

Street Address: ___________________________________________________

City: ___________________  State: ______  ZIP: ______________________

Home Phone: _______________  Cell Phone: _________________________

**Email Address (FAU): _______________________

Medical Area:  Allopathic  Osteopathic
    Medicine  Medicine:
    Dentistry  Podiatry:
    Optometry:  Pharmacy:
    Veterinary  _______________________
    Medicine  Specify:
    Other:  _______________________

Major: _______________________

Please check one of the following and sign below:

☐ Yes, I give my permission to be photographed by the Pre-Health Professions Office for possible use on the bulletin board, and I give permission for my name and email address to be given to another student who is applying to the same school where I was accepted.

☐ No, I do not wish to be photographed or have other students contact me.

☐ Yes, my picture can be displayed, but no email contact with student(s)

Signature: _______________________________________