

Confidential Evaluation Request Form
(Type or Print Clearly)

Name: _____ SID#: _____
 AAMC ID#: _____ (if available)

I authorize the Health Professions Committee to obtain and transmit any pertinent information concerning my record at the College of Charleston.

Signature Date

I hereby voluntarily waive and relinquish access to my confidential Health Professions File and Report.	I retain my right of access to my Health Professions File.
Signature	Signature

Evaluators from whom I have/will request recommendations (for professors indicate department; for others indicate position and place of work):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Professional schools to which I am applying and to which my Health Professions Committee Report should be sent. (If more than ten, so indicate below and list on the reverse side.)

Professional School	Address
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	