Verification of Clinical and Research Work

Student Instructions: Please complete the top half of this form, and then give this form to your supervisor who may submit the form by mail, email or fax.

Columbia University Postbacalaureate Premedical Program
404 Lewisohn Hall, MC 4109
2970 Broadway
New York, NY 10027
Fax: (212) 854-7257, Attention: Postbac Premed Program
Email: gspostbac@columbia.edu Subject: Clinical and Research Work Verification

Student Name: _______________________________________ UNI: ____________________________

Name of Institution, Department, Division, and Program: ______________________________________________________________________________________

Position Description: __________________________________________________________________________________________________________________

Start Date: _______________ End Date: _______________ Completed Hours: _____________________

This position is:   Paid   Volunteer

Supervisor Name: ______________________________________________________________________

Student’s Signature _____________________________________________________________________

Supervisor Information
To be eligible for our premedical committee letter, students are required to document the completion of clinical or research work either volunteer or paid. On occasion, it is necessary for the student to complete these hours at more than one site. We hope that you will be willing to complete this form, even where the student has not completed enough hours to be eligible for your own letter.

Requirements:
Columbia Postbac Premed students: 120 hours (minimum)
Columbia University School of General Studies undergraduate premeds: 80 hours (minimum)

This form is provided for your convenience in communicating with our office about a student’s work hours. Thank you for your supervision of this future healthcare professional.

Name: _____________________________ Title: ____________________________________________

Phone Number: ______________________ Email Address: _____________________________________

This is to verify that the student named above has completed to date a total of _____ hours of work in clinical settings at our hospital/institution and under the direction of our office.

Signature ___________________________________________ Date __________________

Additional comments describing the student’s responsibilities or qualities as a healthcare worker would be most welcome. Please use the reverse side of this form or attach your comments on your institution’s letterhead stationery.