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

Student Name: _____________________________________________________ UNI: __________________________

**Worksite**  
Name of Institution, Department, Division, and Program:

________________________________________________________________________________________

Position Description: ____________________________________________________________

________________________________________________________________________________________

Start Date: ___________  End Date: ___________

This position is: ☐ Paid  ☐ Volunteer

Supervisor Name: ________________________________________________________________

Student’s Signature ______________________________________________________________

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 or research settings at our hospital/institution and under the direction of our office.

Signature ___________________________ Date ___________________