Verifying 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-letters@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 __________________