

NEW YORK UNIVERSITY SCHOOL OF MEDICINE
Office of Registration/Student Records
550 First Avenue
New York, NY 10016

EVALUATION OF ELECTIVE/SUBINTERNSHIP

STUDENT'S NAME:

LAST _____ FIRST _____ MI _____

INSTITUTION AT WHICH ELECTIVE/SUBINTERNSHIP WAS TAKEN:

NAME: _____

ADDRESS: _____

ELECTIVE/SUBINTERNSHIP TAKEN:

DEPARTMENT: _____

TITLE: _____

GRADE: _____

Please indicate Pass or Fail

DATES: _____ to _____

THIS EVALUATION MAY BE SUBJECT TO STUDENT REVIEW UNDER THE FAMILY
EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 (FERPA).

COMMENTS: _____

NAME OF ATTENDING PHYSICIAN _____

Print or Type

SIGNATURE: _____ DATE: _____

Note: Credit will not be given for an elective/subinternship until this form is completed and returned to the Office of Registration/Student Records.