



Pre-Health Professions Office
 Charles E. Schmidt College of Science
 777 Glades Road
 Boca Raton, FL 33431
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 fax: 561.297.3388
 www.fau.edu

ACCESS WAIVER

It is your right as a student to review your file in the Pre-Health professions Office. However, persons completing faculty evaluations and letters of recommendation on your behalf often prefer their statements to remain confidential. **It is our opinion that comments provided on a confidential basis are likely to be more meaningful.** Therefore, the Pre-Health Professions Office is affording you the opportunity to waive your right of subsequent access to your file.

In any event, your waiver of access is not a requirement for consideration of your application or any other services or benefits from the Pre-Health Professions Office, Charles E. Schmidt College of Science, Florida Atlantic University.

Your decision to retain or waive the right of subsequent access to your file shall be noted on all evaluation requests from the Pre-Health Professions Office, and a copy of this access waiver will be forwarded with your packet to all the professional schools of your choice.

I **DO** WAIVE MY RIGHT OF SUBSEQUENT ACCESS TO MY CONFIDENTIAL FILE IN THE PRE-HEALTH PROFESSIONS OFFICE, CHARLES E. SCHMIDT COLLEGE OF SCIENCE, FLORIDA ATLANTIC UNIVERSITY.

I **DO NOT** WAIVE MY RIGHT OF SUBSEQUENT ACCESS TO MY CONFIDENTIAL FILE IN THE PRE-HEALTH PROFESSIONS OFFICE, CHARLES E. SCHMIDT COLLEGE OF SCIENCE, FLORIDA ATLANTIC UNIVERSITY.

 Signature

 Date

 (Please print name)

 Student ID Number

PRE-HEALTH PROFESSIONS OFFICE FILE INFORMATION FORM

Date: _____ Student ID#: _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

****Email Address (FAU):** _____

Medical Area:	Allopathic	<input type="checkbox"/>	Osteopathic	<input type="checkbox"/>
	Medicine		Medicine:	
	Dentistry	<input type="checkbox"/>	Podiatry:	<input type="checkbox"/>
	Optometry:	<input type="checkbox"/>	Pharmacy:	<input type="checkbox"/>
	Veterinary	<input type="checkbox"/>		
	Medicine			
	Other:	<input type="checkbox"/>	Specify: _____	

Major: _____

Please check one of the following and sign below:

- Yes, I give my permission to be photographed by the Pre-Health Professions Office for possible use on the bulletin board, and I give permission for my name and email address to be given to another student who is applying to the same school where I was accepted.
- No, I do not wish to be photographed or have other students contact me.
- Yes, my picture can be displayed, but no email contact with student(s)

Signature: _____