

Feinberg School of Medicine – MD Admissions Acceptance Form

Name: _____

AAMC ID#: _____

_____ I accept the offered appointment as a student at the Feinberg School of Medicine and agree to the following stipulations:

1. I agree to comply with all Feinberg requirements for student health including immunizations, drug testing, and periodic health screening.
2. I agree to consent to a criminal background check by Certiphi Screening, Inc. in association with the Association of American Medical Colleges as required by state law (*Illinois Medical School Matriculants Criminal History Records Check Act*).
3. I agree to provide a final transcript from previous degree programs.
4. I also understand that the University reserves the right to rescind this offer of admission should information in the application be determined to be inaccurate, misleading or incomplete or should the University receive information, which in its judgement, negatively impacts my character or ability to successfully complete the degree program. In the event such information is discovered, I will be given an opportunity to explain that information, and the Dean (or designee) will render a final decision. A decision to rescind the offer of acceptance will be at the sole discretion of the Dean (or designee) and is not subject to appeal.

_____ I decline the appointment. Please provide reason: _____

_____.

Signature: _____

Date: _____

Contact information prior to matriculation:

Address: _____

Cell Phone: _____

Please fax or mail the completed form to:

Warren H. Wallace, MD

Feinberg School of Medicine – Admissions

303 East Chicago Avenue, Morton 1-606

Chicago, IL 60611

Fax: 312-503-0550