HUMANITIES AND MEDICINE PROGRAM
MOUNT SINAI SCHOOL OF MEDICINE

Request for Letter of Recommendation

Recommendation for ___________________________________________
(Student's Name, School, Class)

From _______________________________________________________
_______________________________________________________

Under the Family Educational Rights and Privacy Act, letters of recommendation will be
made available to a student, upon request, unless s/he has waived her/his rights by signing below.

I hereby do ____ do not ____ waive my right
(indicate one)
to inspect this evaluation.

_________________________________  _________________
(Signature of Student)     (Date)

If student has chosen to waive rights, mark letter CONFIDENTIAL. Send letter, along with this form to:

Humanities and Medicine Program
Mount Sinai School of Medicine
Box 1632
One Gustave L. Levy Place
New York, NY 10029

**Deadline for receipt of letter of recommendation is October 15.**