

**ORGANIZATION OF STUDENT REPRESENTATIVES (OSR) CERTIFICATION FORM**



**The signature of the Student Affairs Officer is REQUIRED to become an official OSR representative** (Please note that all names appearing on this form as OSR representatives will replace the existing representatives currently listed in the AAMC database, unless otherwise specified.)

**Association of  
American Medical Colleges**  
2450 N Street, N.W., Washington, D.C. 20037-1127  
T 202 828 0400 F 202 828 1125  
www.aamc.org

**This certifies that the following individual has been selected as the OSR PRIMARY Representative from this medical school:**

**Name of Student** \_\_\_\_\_  
Best Mailing Address \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ \*DOB \_\_\_\_\_  
Date of Graduation: \_\_\_\_\_ \*State designated on your AMCAS application \_\_\_\_\_

**This certifies that the following individuals have been selected as OSR ALTERNATE Representatives from this medical school:** (If you presently have alternate reps and are designating NEW alternate reps, please indicate which rep(s) should be removed from the AAMC database.)

**Name of Student (1)** \_\_\_\_\_  
Best Mailing Address \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ \*DOB \_\_\_\_\_  
Date of Graduation: \_\_\_\_\_ \*State designated on your AMCAS application \_\_\_\_\_

**Please remove:** \_\_\_\_\_

**Name of Student (2)** \_\_\_\_\_  
Best Mailing Address \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ \*DOB \_\_\_\_\_  
Date of Graduation: \_\_\_\_\_ \*State designated on your AMCAS application \_\_\_\_\_

**Please remove:** \_\_\_\_\_

**Name of Student (3)** \_\_\_\_\_  
Best Mailing Address \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ \*DOB \_\_\_\_\_  
Date of Graduation: \_\_\_\_\_ \*State designated on your AMCAS application \_\_\_\_\_

**Please remove:** \_\_\_\_\_

Our students are selected as OSR Representatives via:

- \_\_\_\_\_ Election by the student body
- \_\_\_\_\_ Appointment by the Student Council/Government
- \_\_\_\_\_ Appointment by the Dean
- \_\_\_\_\_ Other (please explain) \_\_\_\_\_

**Medical School:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
PRINT: Name of Student Affairs Officer

\_\_\_\_\_  
Signature of Student Affairs Officer

**Please mail or fax completed form to Julie Taylor, Student Affairs and Programs  
AAMC, 2450 N Street, NW, Washington, DC 20037-1126 Fax: 202/862-6060**