ORGANIZATION OF STUDENT REPRESENTATIVES (OSR)
CERTIFICATION FORM

OSR | AAMC

Date: _____

Medical School: _____

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

Name of Student: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Email: _____
Date of Birth: _____ Graduation Date: _____

This certifies that the following individuals have been selected as OSR ALTERNATE Representatives from this medical school: (Please list **ALL** reps - current and new. *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.*)

Name of Student (1): _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Email: _____
Date of Birth: _____ Graduation Date: _____

Name of Student (2): _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Email: _____
Date of Birth: _____ Graduation Date: _____

Name of Student (3): _____
Mailing Address: _____
City: _____ State: _____ Zip Code _____
Telephone: _____ Email _____
Date of Birth: _____ Graduation Date _____

Name of Student (4): _____
Mailing Address: _____
City: _____ State: _____ Zip Code _____
Telephone: _____ Email _____
Date of Birth: _____ Graduation Date _____

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 specify) _____

_____ _____
PRINT: Name of Student Affairs Officer Signature of Student Affairs Officer

NOTE: The signature of the Student Affairs Officer is REQUIRED to become an official OSR representative

Please **scan and email** completed form to osr@aamc.org; Phone: (202) 862-6006)