ORGANIZATION OF STUDENT REPRESENTATIVES (OSR) CERTIFICATION FORM



Date:		
Medical School:		
his certifies that the following individual chool:	has been selected as the OSR PRI	MARY Representative from this medical
Name of Student:		
Mailing Address:		
City:	State:	Zip Code:
Telephone:	0 1 11 5	
Date of Birth:	Graduation Date:	
chool: (Please list <u>ALL</u> reps - current and	new. If you are designating NEW alterage note that all names appearing or	ERNATE Representatives from this medicernate reps, please indicate which rep(s) shound this form as OSR representatives will replace is especified.)
Mailing Address:	0/-/-	71. 0. 1.
City: Telephone:	State: Email:	Zip Code:
Date of Birth:	Graduation Date:	
PLEASE REMOVE:		
Name of Student (2):		
Mailing Address:		
City:	State:	Zip Code:
	Email:	
Date of Birth:	Graduation Date:	
PLEASE REMOVE:		
Name of Student (3):		
Mailing Address:		
City:	State:	Zip Code
Telephone: Date of Birth:	Email Graduation Date	
PLEASE REMOVE:		
ur students are selected as OSR Represen	ntatives via:	
Election by the student body	udent body Appointment by the Student Council/Government	
Appointment by the Dean	he Dean Other (please explain)	
PRINT: Name of Student Affairs Officer	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 Monique Mauge (Email: mmauge@aamc.org; Phone: (202) 862-6006)