



Albert Einstein College of Medicine

Office of the Registrar
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Belfer Building, Rm 210
Bronx, NY 10461

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Einstein-MDregistrar@einsteinmed.org

Transfer Class Form (MD)

Student Name

Banner ID #

TRANSFER to the CLASS OF: _____ **EFFECTIVE DATE:** _____

I will be working with: _____

Location: _____

Dates of Research: Start Date _____ End Date _____

I will be dropping the following courses/clerkships: _____

I acknowledge that if my research begins after the start of the fourth year, I will register for electives, clerkships, or vacation to account for my time.

My parent receives employee tuition benefits on my behalf

Student's Signature: _____ Date: _____

Dean for Student's Signature: _____ Date: _____

Office of Student Finance: _____ Date: _____

International Students Office: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO THE REGISTRAR'S OFFICE-BELFER 210

OFFICE USE ONLY

Emailed to Occupational Health Date: _____

Update:

___ **Banner** ___ **AAMC-SRS** ___ **Student File**