Albert Einstein College of Medicine

Office of the Registrar
Phone: 718.430.2102
Einstein-MDregistrar@einsteinmed.edu

Research Year Registration Form (MD)

Student Name: _____ **Banner ID #:** _____

Please complete the information below:

Briefly describe your research project, including your learning goals and timeline:

Start Date: _____ End Date: _____ The research end date will coincide with the end of the academic year for the class into which you are transferring.

I will be working with: _____

Location: _____

Required Signatures:

Student: _____ Date: _____

Research Mentor: _____ Date: _____

Director of Scholarly Impact and Research Program: _____ Date: _____

Assistant Dean for Learning Communities: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO Einstein-MDRegistrar@einsteinmed.edu along with a Transfer Class Form. You do not need to obtain signatures from Student Affairs or Student Finance on the Transfer Class Form, as these will be obtained on your behalf.

OFFICE USE ONLY

Update:

☐ **Banner** ☐ **AAMC-SRS**