



Albert Einstein College of Medicine

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

Transfer Class Form (MD)

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

Transfer to the class of: _____ Effective Date: _____

Reason for Transfer:

___ Research ___ Additional Degree ___ Leave of Absence ___ Deferred Coursework

Please list all scheduled courses that you will be dropping in accordance with your class transfer

If transfer is for an additional degree, please complete the information below:

Name of Program: _____

Start Date: _____ End Date: _____ (all end dates are tentative)

Location: _____

Required Signatures

Student: _____ Date: _____

Office of Student Affairs: _____ Date: _____

Office of Student Finance: _____ Date: _____

PLEASE RETURN THE COMPLETED FORM TO Einstein-MDRegistrar@einsteinmed.edu.

OFFICE USE ONLY

Update:

___ **Banner** ___ **AAMC-SRS**