



# New York Medical College

## Address Information

- School:  School of Health Sciences & Practice  
 Graduate School of Basic Medical Sciences  
 School of Medicine
- NYMC Employee?  Yes  No

If necessary, please submit changes to Emergency Contact information on the appropriate form.

Student ID Number \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Middle \_\_\_\_\_

### PERMANENT ADDRESS

*This is your primary residence or the permanent residence of your parents or guardian if you live at a local address during the academic year. Your NYMC mail is sent to this address if you do not have a separate mailing address.*

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Country (if not u.s.) \_\_\_\_\_ Address Effective Date \_\_\_\_\_

Permanent Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### MAILING ADDRESS

*This is your local address and the address where you would like mail from NYMC sent, only include if different from your Permanent Address.*

Street Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ County \_\_\_\_\_

Country (if not u.s.) \_\_\_\_\_ Address Effective Date \_\_\_\_\_

Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### BUSINESS ADDRESS

*This is your employment address. Generally, this information is used to contact you in the event of a class cancellation or contact during non-class daytime hours. It can be inactivated by the Office of the Registrar at your request.*

Name of Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Bus Phone \_\_\_\_\_

### SCHOOL OF MEDICINE ONLY

Do you want an address printed in the student directory? Y N

Do you want a telephone printed in the student directory? Y N

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

For Office Use: Processed (date) \_\_\_\_\_ Initials \_\_\_\_\_ Department: \_\_\_\_\_