NEW YORK MEDICAL COLLEGE

OFFICE OF STUDENT AFFAIRS
ADMINISTRATION BUILDING, 40 SUNSHINE COTTAGE ROAD, VALHALLA, NEW YORK 10595
TEL 914-594-4498 FAX 914-594-4613

STUDY PARTNER MATCH:
WAIVER OF CONFIDENTIALITY

I, _____(full name of student), hereby give the Office of Student Affairs at New York Medical College permission to release my contact information to another NYMC student in search of a study partner for the _____ (full name of course) course. Further, I acknowledge and agree that New York Medical College shall not be responsible for any activities or outcomes as a result of any pairing with a study partner.

Signature _____

Date_____

I also give Dr. Petersen permission to consult with course directors to set up the most ideal pairing: Yes/No (circle one)

Preferred email: _____

Preferred phone number: _____

Please return the original, signed, form to:

Dr. Kristina H. Petersen
Director of University Academic Support Programs
Student Affairs
40 Sunshine Cottage Road
Valhalla, NY 10595