Funded Visiting Elective Program for Students Underrepresented in Medicine

Name: ___________________________________________ Date: __________________________

Last        First        M.I.

Address: ____________________________________________

Street City/State/Zip Code

Phone: ___________________________ Email: ____________________________

Medical School: ____________________________

Race/Ethnicity: □ Black □ African □ Hispanic
☐ African American Please describe ____________________________
☐ Caribbean-American Please describe ____________________________
☐ Other Please describe ____________________________
☐ Native American
☐ Pacific Islander

Gender: □ Male □ Female □ Other USMLE Step 1 Score: _________

Department of Interest:

Elective Block of Interest: □ July – August
☐ August – September
☐ September – October
☐ October – November

Please send complete information sheet to:

Mail: Mason Patenaude, LMSW

Office of Diversity Affairs
550 1st Avenue, MS G62
New York, NY 10016

Email: Mason.Patenaude@nyumc.org

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