

MASTER OF MEDICAL SCIENCE PROGRAM
DEPARTMENT OF ANESTHESIOLOGY
EMORY UNIVERSITY SCHOOL OF MEDICINE
57 EXECUTIVE PARK SOUTH
SUITE 300
ATLANTA, GA 30329

APPLICANT'S STATEMENT

I, _____ (ENTER FULL NAME), have read and understand all sections in this *Description of Program and Application for Admission* for the Master of Medical Science Program, Department of Anesthesiology, Emory University School of Medicine. I declare that all information provided in this application form and in support of my application is complete and true, and I hereby consent and permit Emory University to contact those persons and entities whose names are set forth as references or are otherwise set forth herein in order to supplement and verify the information that I have supplied. I hereby consent to the provision/release to Emory University of such information by those persons and entities who may be contacted in these regards, and I hereby release any such persons/entities from any claims that I may have with regard to such information and further agree and covenant not to sue such person/entities on account of any disclosure by them of this information. I agree that, if accepted to this Emory University program, I will abide by all rules and regulations of Emory University. Furthermore, I understand and agree that providing false or incomplete information in this application or in support of this application is just cause for rejection of my application or, in the case of my acceptance, for immediate dismissal from Emory University.

SIGNATURE

_____-_____
DATE

PRINTED NAME

EMAIL ADDRESS