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**Matriculate Class 2020**

**Applicant Authorization to Release HPAC Composite Letter of Evaluation—Submit to Ms. Emrick by May 1, 2019**

I authorize Lafayette’s Health Professions Advisory Committee to consult my educational record at Lafayette College and my HPAC file materials for the purpose of completing a Composite Letter of Evaluation (CLoE) on my behalf for admission to the health professions schools specified below. I understand this may reveal information from my record as you deem appropriate and necessary for the above-stated purpose, including data (1) pertaining to my education at other institutions previously attended which is a part of my education record at Lafayette, (2) contained in confidential Letters of Recommendation I solicited for the above-stated purpose, and (3) reflected in the entire HPAC on-campus review and interview process. I have included my application service IDs as well as my MCAT/DAT/OAT/GRE scores (if known) and test dates.

**Information may be released to the following schools:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List all Application Identification Numbers if known (AAMC & AMCAS Letter/ AACOMAS/VMCAS/AADSAS/ OptomCAS):

|  |  |
| --- | --- |
| APPLICATION SERVICE | ID NUMBER |
|  |  |
|  |  |

List all admissions tests scores (if known) and date completed/to be taken:

|  |  |  |
| --- | --- | --- |
| TEST | SCORE (include components) | DATE |
|  |  |  |
|  |  |  |
|  |  |  |

I hereby **WAIVE\_\_\_\_\_** or **DO NOT WAIVE** **\_\_\_\_\_** (***check only one***) my right of access (granted under the Family Educational Rights and Privacy Act of 1974) to see any part or all of the HPAC CloE and all attendant information prepared pursuant to this release. I understand that it will be used solely for admissions to health professions schools, relevant post-baccalaureate programs, or applications for financial aid/scholarships to fund these endeavors. I understand further that the recipients indicated will be informed of my decision regarding this waiver. Finally, I understand that I will be assessed a **one-time processing fee of $50.00** for all schools I designate, and I agree to pay it**.**

**APPLICANT SIGNATURE: DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**