



**Yale University**  
**School of Medicine**  
<http://info.med.yale.edu/education/finaid>

Yale University School of Medicine  
 Financial Aid Office  
 367 Cedar Street  
 New Haven, CT 06510

Phone: (203)785-2645  
 FAX: (203) 785-2924

**Certification of Information Form**

**Statement of Understanding**

School Affiliation: Medicine \_\_\_\_\_ Physician Associate \_\_\_\_\_ (Please check one)

*All students are required to complete this certification.*

I understand that it is my responsibility to provide the Financial Aid Office with information as requested. I also understand that the Financial Aid office has the right to withhold financial aid altogether if these forms and other requested information is not submitted by the established due date for the academic year. I understand that if I purposely give false information in the aid application process and receive aid from federal and university approved programs, I may be subjected to a fine, imprisoned or both. I certify that I have read all the information regarding my rights and responsibilities. I understand that if I receive funds from other sources, such as scholarship from outside agencies, work during the academic year and/or research, I am required to report this to the financial aid office and my financial aid award may be adjusted.

Student's Name (please print) \_\_\_\_\_ SSN# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Information Release Permission**

*All students are asked to complete this certification.*

Pursuant to Section 438(b) (1) of the Family Education Rights and Privacy Act of 1974, I hereby give consent to Yale University School of Medicine for the release of information including evidence of financial need, personal data and academic data.

Student's Name (please print) \_\_\_\_\_ SSN# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Donor Certification**

*Scholarship Recipients are asked to complete this certification.*

When receiving Yale Scholarship, we sometimes need a student to write a thank you not to the donors of our endowment funds. These funds are monitored by the Development Office. You may be asked by that office to provide information about myself consisting of premedical background, residency preferences, personal and professional interests and academic progress. We will need your cooperation in this matter. Please sign the statement listed below if you are willing to write a thank you letter.

I will provide information about myself consisting of premedical background, residency preferences, personal and professional interests and academic progress.

Student's Name (please print) \_\_\_\_\_ SSN# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_