SUNY Downstate Medical Center

A L T E R N A T E R E P L Y F O R M

PLEASE RESPOND WITHIN TWO WEEKS

OF THE DATE OF YOUR ALTERNATE LETTER

I _____(print your full name), **ACCEPT** your offer to be placed on the ALTERNATE LIST for the entering class of **2019** in the _____.
(Program Name)

I understand that I will be notified by the Office of Admissions should an opening become available.

I _____(print your full name), **DECLINE** to be placed on the ALTERNATE LIST for the entering class of **2019**.

We would appreciate knowing why you do not want to be placed on the ALTERNATE LIST:

_____

_____

PERSONAL INFORMATION

Address
Street Address

_____
City **State** **Zip Code**

Daytime Telephone Number _____

_____
Signature **Date**

_____ _____
Student ID Number (The one used (Username) to access your Admission Checklist) E-mail

Please return this form to:

SUNY Downstate Medical Center
Office of Student Admissions
450 Clarkson Avenue, MSC #60
Brooklyn, NY 11203-2096