University Of Rochester School of Medicine and Dentistry

Medical Center Athletic Membership WAIVER Form
2009-2010

Waivers must be returned no later then September 30 to receive credit for the fall semester and January 31 for the spring semester.

Student Information

NAME: (*Please Print*) _____

STUDENT UID#: _____

DATE: _____

SIGNATURE: _____

IF YOU WOULD LIKE BOTH SEMESTERS WAIVED, PLEASE CHECK OFF "BOTH" SEMESTERS, OTHERWISE ONLY THE SEMESTER CHECKED WILL BE WAIVED. ($126 per semester)

WAIVER REQUEST: Fall _____ Spring_____ Both ____

DATE IN ISIS: Fall _____ Spring_____