UNIVERSITY OF MIAMI
MILLER SCHOOL of MEDICINE

ERAS TOKEN REQUEST

TO BE COMPLETED BY THE MD GRADUATE		
Please use the name on your enrollment records.		
Last Name:	First Name:	Middle Initial:
Class of:		
E-mail Address:		
Last 4 of SSN#:		
Date of Birth (D.O.B.):		
Phone Number:		

AUTHORIZATION OF PERSONAL INFORMATION RELEASE

I hereby authorize the use of my personal information to obtain an ERAS token for the

_____ academic year.

OFFICE OF STUDENT AFFAIRS	
Student Signature:	Date: