Caribbean Medical University
School of Medicine

Admissions Acceptance Form

This is your enrollment agreement with the Caribbean Medical University. Please retain a copy for your records. Please sign and return this form along with the seat deposit by mail or fax to the Office of Admissions at (302) 397-2092

IF NOT PRE-FILLED, PLEASE PRINT CLEARLY AND IN CAPITALS

Office of Admissions
Caribbean Medical University
5600 N River Road Suite 800
Chicago, IL 60018

Phone: (888) 877 4268
Fax: (302) 397 2092
Email: admissions@cmumed.org

Student Information

Student ID

Last Name First Name

Address

Email Phone Number ( )

Enrollment Information

Program Semester

Category Acceptance Date

Memorandum of Understanding

I understand and accept the offer made to me by Caribbean Medical University and I acknowledge that my enrollment in the aforementioned program will be governed by the School's Terms of Enrolment (attached) as well as other applicable school's policies and procedures. I certify that I have read and agree to comply with the policies and procedures outlined in the Terms of Enrollment. The undersigned is a student duly enrolled in a study program for which credit shall be granted upon successful completion of the program.

Signature Date m m / d d / y y y y

If you do not complete all the questions on this form, it may not be possible for Caribbean Medical University to enroll you. You have the right to access personal information that Caribbean Medical University holds about you, subject to any exceptions in relevant legislation. If you wish to seek access to your personal information or enquire about the handling of your personal information, please contact the Admissions Officer at (888) 877 4268.

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