UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

DATE: _____

REQUEST FOR ERAS TOKEN

Graduated Name: _____

Class: _____

Email Address: _____

Last 4 # of SSN _____

DOB: _____

PHONE: _____

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

_____Academic year.

Signature: _____

PLEASE SUBMIT TO THE REGISTRAR'S OFFICE BY EMAIL or FAX

EMAIL : MEDREGISTRAR@MED.MIAMI.EDU

FAX : **305-243-8151**