



SCHOOL OF MEDICINE

CASE WESTERN RESERVE  
UNIVERSITY

**Center for Global Health and Diseases**

Certificate Global Health Checklist

\_\_\_\_\_  
Date

☐

Undergraduate

☐

Graduate

\_\_\_\_\_  
Expected Graduation Date

\_\_\_\_\_  
Major/Department

\_\_\_\_\_  
Advisor

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Initial

\_\_\_\_\_  
CWRU Student ID NO.

Courses taken to fulfill criteria:

Required

Required

Required

Department approved elective

List what you hope your future involvement will be in the area of global health:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Advisor Signature

\_\_\_\_\_  
Framework Program Coordinator Signature

The above named student is confirmed for the following graduate date

\_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
Registrar or Authorized Department Official Signature

**Return completed form to: Center for Global Health & Disease Educational  
Coordinator, BRB 4<sup>th</sup> Floor, LC: 4983**

Mailing Address:  
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CWRU School of Medicine  
Biomedical Research Building  
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