

**MEMORIAL UNIVERSITY MEDICAL CENTER
ELECTIVE APPLICATION FORM FOR NON-MUSM STUDENTS**

Form must be returned with the Immunization Certificate in order to be considered. Incomplete applications will be returned to the student

I. To be completed by the student

Name _____ Class of _____
Date of Birth _____ Social Security # _____
Address _____
Phone Number _____
Medical School Name and Address _____

Course Name and Number _____
Dates Requested _____ to _____
Alternate dates: _____ to _____

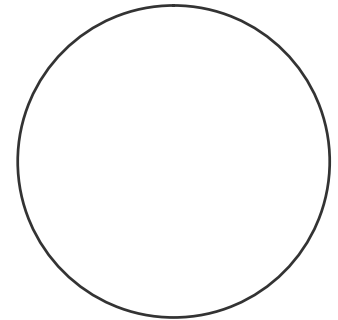
I agree to abide by all Memorial University Medical Center rules and regulations.

Student Signature _____ **Date** _____

II. To be completed by the Dean of Students or designated official

*******(School seal is required in this section)*******

____ Yes ____ No Will the student named above pay tuition at your school during the time period listed above?
____ Yes ____ No Is the student approved and in good standing to take this elective for credit?
____ Yes ____ No Has the student taken and passed all prerequisites?
____ Yes ____ No Will an evaluation be required at the end of the elective?
____ Yes ____ No Is the student covered by malpractice insurance that covers them while visiting? \$1,000,000/\$3,000,000
____ Yes ____ No Does the student's health care insurance cover them while at our institution and does the policy provide for repatriation in the event of serious illness or death?
____ Yes ____ No Has the student taken and passed the USMLE Step I exam or it's equivalent?
____ Yes ____ No Is the student current on all vaccinations, including a TB-titer within the preceding 6 months and proof of immunity to varicella?



Name of Reporting Official _____ **Title** _____

Signature _____ **Date** _____

III. To be completed by Medical Student Program Coordinator _____

____ Course **is** available at the requested time
____ Course **is not** available at the requested time. Student has been contacted and the alternative course or date agreed to, is _____

IV. To be completed by the host department chairman or department designee

____ Admission of the student named above **is** approved.
____ Admission of the student named above **is not** approved.
The student will report to _____
Department Contact is _____

Signature _____ **Date** _____

V. To be completed by the Director of Medical Education

____ Admission of the student named above **is** approved.
____ Admission of the student named above **is not** approved.

Signature _____ **Date** _____