

FOREIGN VISITING STUDENT APPLICATION
Office of the Registrar – Box 1257
Mount Sinai School of Medicine
One Gustave L. Levy Place New York, NY 10029

Name _____ Date of Birth ____/____/_____
 Address _____ E-mail _____
 _____ Phone _____/_____/_____
 _____ Country City Number
 Citizenship _____ Male _____ Female _____
 Medical School _____ What Country? _____
 I am currently a ____year student in a ____year program

This section to be filled out by Dean or comparable school official of medical school where the student is enrolled.

The medical student above is in good standing at this institution. He/She _____ will _____ will not pay tuition at our institution during the period indicated below. Personal health coverage _____ is _____ is not in effect while the student is away from our school. Malpractice insurance _____ is _____ is not in effect while the student is attending the elective.

SCHOOL SEAL

 TITLE OF SCHOOL OFFICIAL Signature Date

*****List Core Clerkships that you will have completed at the time of your proposed elective**

Clerkship _____ - _____ Dates Clerkship _____ - _____ Dates

Clerkship _____ - _____ Dates Clerkship _____ - _____ Dates

Clerkship _____ - _____ Dates Clerkship _____ - _____ Dates

(MONDAY) (FRIDAY)

FOR DEPARTMENT USE ONLY – DO NOT WRITE IN THIS SECTION

The above elective _____ has been approved for the requested time _____ is not available
 _____ is available for the following dates FROM _____ TO _____
 Contact _____ at _____
 Department contact person telephone number

IF THE STUDENT HAS BEEN APPROVED TO TAKE THE ELECTIVE AND CANNOT ATTEND, AT LEAST ONE MONTH'S NOTICE MUST BE GIVEN SO THAT OTHER STUDENTS ON THE WAITING LIST CAN HAVE THE OPPORTUNITY TO PARTICIPATE IN OUR ELECTIVES PROGRAM.

HIPAA (Health Insurance Portability & Accountability Act, a Federal law) compliance is now required for all clinical students with exposure to patients. Students must successfully complete on-line training module and testing at Mount Sinai, regardless of previous HIPAA testing at other institutions.

***** Core Clerkship must be filled out or application will not be processed.**

ELECTIVES REQUEST FORM

Elective Choices:

Please list in order of preference and include the exact name of the elective and the entire code number, including the departmental pre-fix.

Example:

____Anesthesia____ ANE - 002 0021 ____MSSM____ Dates: 01/01/20XX - 02/01/20XX
Title of Elective Elective Number MSSM or Affiliate MM DD YY MM DD YY

(MONDAY) (FRIDAY)

____-____-____ Dates: ____/____/____ - ____/____/____
Title of Elective Elective Number MSSM or Affiliate MM DD YY MM DD YY

(MONDAY) (FRIDAY)

____-____-____ Dates: ____/____/____ - ____/____/____
Title of Elective Elective Number MSSM or Affiliate MM DD YY MM DD YY

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(MONDAY) (FRIDAY)

____-____-____ Dates: ____/____/____ - ____/____/____
Title of Elective Elective Number MSSM or Affiliate MM DD YY MM DD YY

(MONDAY) (FRIDAY)