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____ Social Security Number _______/_________________________________

Address ____ e-mail ____

____ Phone ______________/______________/_________________________

(Include Country Code, City and Number)

Citizenship ____ Male ______________ Female ______________

Medical School ____ What Country? ____

I am currently a ___________year student in a __________ year program.

Date of birth ____/_____/_______
Month/ day/ year

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.

_____________________________________ __________________________________

TITLE OF SCHOOL OFFICIAL Signature Date SCHOOL SEAL

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

Core Clerkships are courses that every student MUST complete at their home university before they can graduate.

___________________________ - _____________________ ___________________________ - _____________________ 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 tim e _____is not available _____Is available for the following dates FROM _______________ TO _______________

Contact ____________________________________ at ____________________________________ Department contact person phone 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.

ELECTIVES REQUEST FORM

STUDENT NAME: ____

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:

Vascular Surgery__	**SUR 097-1838**	___________________	Dates: _____/_____/_____ - _____/_____/_____
Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
Liver Disease	**Med 198-3002**		(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
			(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
			(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
			(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
			(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year
			(MONDAY) (FRIDAY)
_________________	___ ___ ___ - ___ ___ ___	___________________	Dates: _____/_____/_____ - _____/_____/_____
__ Title of Elective	Elective Number	MSSM or Affiliate	Month / Day / Year – Month / Day / Year