

Visiting Student Application

University Of Rochester School Of Medicine And Dentistry
Student Services Office, Box 601, 601 Elmwood Avenue
Rochester, New York 14642

VISITING STUDENT APPLICATION

NOTE: Applications will be accepted only for students who are final year students in LCME/AOA COCA (Osteopathic) Schools. All visiting students must meet certain health compliance and immunization requirements. Students attending international medical schools in their final year should verify eligibility by contacting: International Medicine Office, SRO, Box 601, University of Rochester School of Medicine and Dentistry, 601 Elmwood Avenue, Rochester, NY 14642, or emailing Mary Garner at Mary_Garner@urmc.rochester.edu . International students are limited by NY State Law to 12 weeks of clerkships.

TO BE COMPLETED BY STUDENT: Please complete one application form for *each* elective desired. Each application must be accompanied by a check for \$100.00 payable to The University of Rochester School of Medicine and Dentistry to cover administrative expenses. Please print or type this form.

Name _____ ID Number _____

Address _____

City _____ State _____ Zip _____ Country _____

Telephone Number _____ Year Level _____

Signature _____

List below the elective desired. List additional options in case you cannot be scheduled for your first choice and/or dates.

COURSE ID	ELECTIVE TITLE	SPONSOR	# WEEKS	DATES
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

TO BE COMPLETED BY THE DEAN OF STUDENTS, or comparable official, of the medical student's school: The student named above is in good standing at this institution and is approved to take this elective(s).

I have enclosed a letter of recommendation.

The student (will) (will not) be covered by basic ambulatory health care. If not covered, the student must carry The University of Rochester's health care at approximately \$30.00 per month. Malpractice insurance (does) (does not) cover the student while away from this school. The student (will) (will not) pay tuition at this school during the extramural period. Academic credit toward the M.D. degree (will) (will not) be awarded upon the receipt of a passing grade. An evaluation of this elective (will) (will not) be required.

Name _____ Title _____

Signature _____ School _____

Address _____

City _____ State _____ Zip _____ Date _____